Addaction - Stratford

Quality Report

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

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

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

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

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

Overall summary

We do not currently rate independent standalone substance misuse services.

We found the following areas of good practice:

- The service had enough staff to care for the number of clients and their level of need. Vacancy rates, turnover and sickness absence were all low. The service did not use bank or agency staff, but was able to rely on a dedicated permanent staff team who had a thorough knowledge of the service and the clients. All staff and volunteers had gone through the appropriate checks to ensure they were safe to work with vulnerable adults.
- The environment was visibly clean, well maintained and supported the safety of staff and clients. It was friendly and welcoming, and part of a general health clinic.
- The service appropriately assessed, recorded and managed any risks from or to each client. It raised and referred safeguarding concerns to the relevant agencies. It had mechanisms in place for reporting and learning from incidents and complaints.
- The service assessed all clients at the start of treatment, using appropriate assessment and monitoring tools and ensured holistic and recovery focused support plans were in place.

Summary of findings

- The service had a suitable range of project workers and clinicians to support clients. This included doctors and nurses who led regular weekly clinics. The service provided group sessions and support for clients to aid recovery. It worked with partner agencies to help clients get further support before and after discharge, and worked with community mental health teams to support clients with a dual diagnosis of mental health and substance misuse. The service also promoted awareness and protection for problems associated with substance misuse, such as hepatitis.
- Staff showed a good understanding of clients' fluctuating mental capacity and of the need for informed consent to treatment. Clients were very appreciative of the support, understanding and respect shown by staff. They felt staff listened to them and fully discussed their care and treatment with them. Clients were fully involved in their treatment and recovery. They were able to access advocacy and other support services through a partner agency. The service supported clients in recovery to become recovery champions, which helped them and peers toward recovery.
- There was no waiting list. The service saw clients promptly and was able to commence assessments and treatments promptly. There were weekly evening and outreach services for clients who found the standard times and location a problem. Appointments ran on time and were very rarely cancelled. The service had a policy and procedure for re-engaging with clients who did not attend for appointments.
- Staff were passionate about their work, and everyone worked together in a positive, co-operative and supportive manner. Absence rates were low, and morale was high. Staff were supervised, appraised, inducted and received proper training. They knew how to raise concerns and were confident to do so if needed.
- Governance groups oversaw the work of the team to ensure quality and performance was maintained. Staff were involved in audits. The service met and regularly exceeded national and local performance targets in treating clients. The service responded to complaints appropriately.

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

- The room used for needle exchange was too small for staff to comfortably close the door. This potentially compromised the dignity and privacy of clients who came to exchange needles.
- The provider should ensure that the dignity and privacy of clients is maintained, by ensuring doors are shut when interactions such as urine testing are taking place.
- Data provided by the service did not clearly reflect training that had been undertaken by staff.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services		We are not currently rating substance misuse services.

Summary of findings

Contents

Addaction - Stratford

Services we looked at

Substance misuse services;

Summary of this inspection

Background to Addaction - Stratford

Addaction Stratford (The Recovery Partnership) provides community based services for adults with drug and/or alcohol related issues. This includes one to one and group based advice, treatment and support, needle exchange and a prescribing service. It is part of Addaction Coventry and Warwickshire, which covers that county and city. Addaction Stratford covers the Stratford area, the towns of Shipston-on-Stour, Wellesbourne, Studley and Alcester, and the surrounding rural area.

We registered this service for diagnostic and screening procedures, and treatment for disease, disorder or injury in 2011. There is a registered manager for the Coventry and Warwickshire service, of which Stratford is one location. Stratford has a manager, who is not a registered manager.

We have previously inspected this service in 2013 and 2014, when it met all standards inspected.

Our inspection team

The team that inspected the service comprised CQC inspector Martin Brown (inspection lead), one other CQC inspector, and an expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using, substance misuse services.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited the service, looked at the quality of the physical environment, and observed how staff interacted with clients
- spoke with nine clients, a volunteer and a substance misuse "recovery champion"
- spoke with the manager and eight other staff members employed by the service provider, including nurses and project workers
- spoke with a doctor holding a clinic on the day of our visit
- spoke with three peer support volunteers
- attended and observed a clinic operating on the day of the visit

Summary of this inspection

- collected feedback using comment cards from eleven clients
- looked at 10 client care and treatment records, including medicines records
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

There were very positive comments about the service by people who used it. Clients, who spoke directly to us, as well as those who filled in comment cards, praised the staff for their supportiveness and the way they treated people with respect. There were positive comments about the cleanliness and tidiness of the service, the politeness of staff, and the timeliness of the service. Other common themes raised by clients included the usefulness of the groups, the good advice, expertise and dedication of staff.

Two people who had previously used other substance misuse services compared Stratford very positively to them. In particular, they praised the friendly and welcoming nature of the service and staff.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The service had enough staff to care for the number of clients and their level of need. Vacancy rates, turnover and sickness absence were all low. The service did not use bank or agency staff, but was able to rely on a dedicated permanent staffing team who had a thorough knowledge of the service and the clients.
- The environment was visibly clean, well maintained and supported the safety of staff and clients, with infection control, storage of equipment and monitoring processes in place to help maintain a safe environment.
- All staff had undergone appropriate checks to ensure they were safe to work with vulnerable adults.
- Staff ensured they appropriately assessed, recorded and managed risks from or to the client. This included any risks the clients might present to themselves, and whether their physical health presented risks that would affect care and treatment. The service reviewed assessments to take account of changing circumstances.
- Staff raised and referred safeguarding concerns to the relevant agencies.
- The service recorded a small number of incidents, which they notified appropriately. The service had mechanisms in place for reporting and learning from incidents and complaints.
- The service had a lone worker policy to ensure staff worked safely. They had learned from an incident and revised procedures accordingly.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The service had enough staff to care for the number of clients and their level of need. Vacancy rates, turnover and sickness absence were all low. The service did not use bank or agency staff, but was able to rely on a dedicated permanent staffing team who had a thorough knowledge of the service and the clients.

Summary of this inspection

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- Staff raised and referred safeguarding concerns to the relevant agencies.
- The service recorded a small number of incidents, which they notified appropriately. The service had mechanisms in place for reporting and learning from incidents and complaints.
- The service had a lone worker policy to ensure staff worked safely. They had learned from an incident and revised procedures accordingly.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff were caring and thoughtful in their approach with clients. They listened to clients and displayed warmth and understanding**.** Doctors in clinics we observed took care to ensure clients understood processes and reasons for treatments and shared in the understanding and desirability of outcomes.
- Clients were very appreciative of the support, understanding and respect given by staff. They felt staff listened to them and fully discussed their care and treatment with them.
- Clients were fully involved in their treatment and recovery. They were able to access advocacy and other support services through a partner agency.

However, we also found the following issue that the service provider could improve:

- Doors were not always shut in rooms where needle exchanges and urine testing took place. This compromised client privacy, dignity and confidentiality.

Are services responsive?

We do not currently rate standalone substance misuse services.

Summary of this inspection

We found the following areas of good practice:

- The service saw clients promptly and was able to commence assessments and treatments in a timely manner. There was no waiting list. Clients were very appreciative of this responsiveness.
- The environment was friendly and welcoming, and part of a general health clinic, which helped reduce any perceived stigma in attending the clinic.
- The service provided weekly evening and outreach services for clients who found the standard times and location a problem.
- Appointments ran on time and were rarely cancelled.
- The service had a policy and procedure for re-engaging with clients who did not attend for appointments.
- The service supported clients in recovery to become recovery champions, which helped them and their peers in recovery.
- Complaints were responded to appropriately.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff were passionate about their work, and everyone worked together in a positive, co-operative and supportive manner. Absence rates were low, and morale was high.
- Staff were supervised, appraised, inducted and received proper training. The service ensured all staff, including volunteers, were recruited appropriately, with appropriate checks to ensure they were able to work with vulnerable adults.
- Staff knew how to raise concerns and were confident to do so if needed.
- Governance committees oversaw the work of the team to ensure quality and performance was maintained. Staff were involved in audits. The service met and regularly exceeded national and local performance targets in treating clients.
- The service was proactive in raising awareness around substance misuse, such as hepatitis awareness.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed 10 client records. All contained a confidentiality agreement and consent to treatment and to sharing of information.
- Staff assessed a client's capacity to understand information at assessment and at each contact. Staff would ask a client to rebook an appointment if the client was heavily under the influence of a substance and unable to understand and retain information. This was part of the client's agreement to access treatment through the service.
- Staff were able to demonstrate their understanding of issues of capacity, how these fluctuated and how they supported clients.
- The provider made no Deprivation of Liberty Safeguards applications in the last 12 months. They were not required to make these.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

- The service was based within a general healthcare centre and shared a main reception, which was bright, airy and included a pharmacy and a coffee shop. The service itself was on the third floor, with supporting offices (staff only) on the first floor. There were lifts, stairs and easy access. The reception area was clean, airy, with comfortable chairs overseen by the reception counter. The offices were secure and clean. All areas were uncluttered and well maintained.
- The service had an up to date health and safety assessment and fire risk assessment. There was an issue with the mains water in the entire building, which was in the process of being resolved. At the time of our visit, staff regarded the taste of the tap water unpleasant, although safe to drink. Staff offered bottled water to clients and visitors who requested a drink. Water coolers were previously provided but the service found the provision of bottled water a less expensive option.
- The premises were cleaned by contract cleaners. They were contracted to clean the premises used by all the services in the building. The manager did not have copies of cleaning schedules, but was satisfied that daily cleaning took place satisfactorily. The manager told us they carried out informal environmental checks of the building daily. If they had any concerns they would contact the named person responsible for managing the cleaning contracts for the building who held copies of the cleaning schedules. The premises were visibly clean and in good order throughout.
- There were panic alarms for staff to use in the event of emergency. The manager told us staff had only needed to use these alarms once in over a year. The alarms were discretely sited and staff were able to demonstrate how easily they could activate them should they need to.
- There was a clinic room which was visibly clean, well-stocked, and in good order. There were hand-washing facilities and adequate amounts of soap and alcohol gel, as well as hand washing posters. The room was well-ventilated.
- The clinic room had an examination couch, blood pressure monitor and weighing scales. Equipment was tested and had been calibrated within the past six months. Cleaning materials for spillages were available for use. There was a fridge containing combined hepatitis A and B vaccinations, which were in date.Staff checked the fridge daily to ensure temperatures were within the acceptable ranges. Staff checked the first aid box monthly.
- Emergency drugs, naloxone and adrenaline, were kept in a locked cupboard and were in date. Naloxone is a medicine used to counter any overdose.
- The room allocated for the needle exchange service was well stocked and in good order. Stock was in date. This room was rather small, and the service had agreed to re-locate the stock to the clinic room.

Safe staffing

- The team at Stratford consisted of a manager, two team leaders (one of whom was also the hepatitis co-ordinator), two administrative staff, and nine project workers. Staffing was sufficient to allow project workers to have caseloads of between 30 and 50. Staff felt these were manageable caseloads.
- A nurse served both Stratford and Leamington sites. If not on site, they were available for staff consultation via

telephone if required. There was also a lead nurse covering the Coventry and Warwickshire sites. Two sessional doctors provided two morning clinics each week.

- Data sent to us by the service recorded staff turnover as 22% in the past twelve months. Three staff changes in a small staff group accounted for this. Of 14 staff, one person had transferred to an adjacent service, one person had moved elsewhere, and one person had left for a change of career.
- The service had three volunteers who helped with administration, reception and group work. Volunteers received full induction and training. Volunteers could be ex-clients who had first become recovery champions, helping support and motivate other clients leading by example.
- Sickness rates were low. Data supplied by the service showed a level of 2% for the three months up to April 2016. There was a member of staff on a fixed contract to cover a long-term absence. There was no use of agency or bank staff documented by the service for the three months up to April 2016.
- Doctors' clinics were held twice weekly on a Tuesday and a Thursday. Doctors offered substitute prescribing and assessment.
- There were daily clinics which offered health checks, blood borne virus testing and detox assessments. The non-medical prescribing nurse attended three times weekly and offered support for prescribing on days when the doctors were not at the service. This meant that clients were able to access health checks and prescriptions every day, Monday to Friday.
- If the non-medical prescribing nurse or doctor called in sick at short notice, the Stratford service would seek cover from another local area of the service.
- All staff had checks to ensure they were suitable to work with vulnerable adults.

Assessing and managing risk to clients and staff

- Each client was risk assessed by staff. The majority of appointments took place at the Stratford premises. Where home visits took place, these were done by two staff for initial visits, or where risk assessments had identified potential risks to staff. Staff assessed any initial referrals involving home visits. We examined 10 client records. All showed that they had an initial risk assessment.Assessments included an exploration of the client's history of substance abuse, risk and any safeguarding children and adults concerns.
- Staff we spoke with were knowledgeable and thorough when they explained how they holistically assessed clients' needs at the point of admission and throughout treatment. Assessments were stored in client paper files and on an electronic recording system.
- A nurse assessed each client's physical health during a health check on admission and an annual health check took place thereafter. The service monitored any deterioration in a client's mental or physical health through key working sessions, attendance the clinics and on collection of prescriptions.
- Staff could regularly discuss safeguarding cases in supervision, through morning meetings and monthly team meetings or as needed with team leaders. All staff had received safeguarding training. Staff gave examples of when and how they had made safeguarding referrals and how they worked with other agencies in promoting safeguarding.
- There was a lone worker policy. This had been revised following a recent concern, so that all staff who were visiting clients had to record where they were going and when they anticipated completing a visit. Staff were aware of this system. The form they were required to complete regarding this was clear and concise. The service had outreach services that opened one day a week, for clients who struggled to get to the Stratford office. One member of staff would staff these. One outreach service had been in a church hall. The service had recognised this was potentially unsafe, and had re-located to a doctor's surgery.
- Clients had to present in person to collect prescriptions. This helped clients to reduce dosages and ensured staff regularly saw them to support them in this.
- The service had a dedicated and trained prescription administrator. Their role was to coordinate and produce batches of prescriptions for clients using a computer-generated program in readiness for doctors to sign and issue to clients. They also coordinated prescription files for clients who hand collected them.

- Staff stored prescriptions in a locked safe and ensured a limited number of staff had access to them. They also monitored use of prescriptions. No medicines were stored on site except for emergency use naloxone and adrenaline. All staff were trained in how to administer naloxone.
- Clients were discouraged from bringing children with them when attending the service. This was because there are no childcare facilities on site and the environment and content of discussion was not appropriate for children. In cases where clients had no choice but to bring their child, as they were the main carer, the service worked with them by offering outreach and home visits.
- There was a clear policy on assessing risks where there were children present in clients' houses and on the use of safe storage boxes for medicines. This included co-signed agreements by client and worker on the acceptance and proper use of such storage.

Track record on safety

- The service had recorded no serious incidents as having required further investigation in the past twelve months to April 2016. They had three incidents where they had notified the police, and three unexpected deaths. The service had notified us of these.

Reporting incidents and learning from when things go wrong

- Staff we spoke with were aware of how to report incidents and what incidents to report. We saw evidence of appropriate incident reporting.
- The service had notified us of three incidents in the past year. Staff had been de-briefed following these, and any resulting learning had been applied.
- A critical incident review group reviewed incidents monthly. The service manager and regional manager attended this group and reported incidents to the national clinical and social governance group. Incidents were discussed locally and then fed back nationally to this group, which was attended by commissioners for the service. This showed the service was open and transparent with commissioners.
- The service had fortnightly development sessions. These could include guest speakers, but also included sessions where staff learned from serious incidents, including deaths. The team would discuss anonymised national or local case studies, which they used as examples for learning.

Duty of candour

- The ethos of the service, and discussions with both staff and clients indicated that staff were open and forthcoming with clients. The critical incident review group showed the service was open with commissioners.

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

Assessment of needs and planning of care

- We examined 10 client records. All clients had a comprehensive assessment completed at the beginning of treatment. This included assessment of psychological, physical, social needs as well as any offending history and safeguarding concerns. Clients who reported alcohol use also completed an alcohol audit and, if required, a severity of alcohol dependence questionnaire.
- The service kept records on a mix of paper and electronic records, with more recent records being recorded electronically. Staff recorded new information about clients from visits or other contacts in individual client case notes. These were then used to update assessments and recovery plans. Our observations showed that staff had a good understanding of clients, and shared knowledge and recovery plans appropriately. Less than half of the recovery plans showed clear evidence that clients had received a copy of their plan. However, all clients we spoke with told us they had discussed their care and recovery and indicated they were a full partner in their recovery. Comment cards also indicated that clients were aware of and involved in their recovery plans. One client recorded on a comment card, "all my goals have been reached" and another spoke of the holistic approach of staff to their treatment. The manager identified that client records may not all be consistently detailed but identified ways they were addressing this within the service. They detailed how workers should record client notes and treatment options. Electronic client records

were stored securely on a password protected web-based case note recording system. Paper records were stored in alphabetical order in the office, which accessible only to staff. The managers and staff members were all responsible for maintaining these files.

Best practice in treatment and care

- Doctors followed National Institute for Health and Care Excellence guidelines in treating and prescribing for clients. When carrying out community detox with clients, nurses ensured clients had proper levels of assessment, support and monitoring. Severity of alcohol dependence questionnaires were completed where clients were being treated for alcohol dependence.
- Staff we spoke with gave us examples of the psychosocial interventions they used with clients. These included motivational interviewing, solution-focused therapy, cognitive behavioural approaches and brief interventions. Group work took place Monday to Friday, with groups operating morning and afternoon on topics such as alcohol awareness, substance misuse, mindfulness and recovery. A typical feedback comment from a client noted, "The groups are factual and useful and listening to others with the same mental state helps."
- The service worked closely with a partner agency that offered peer support, mentoring, family support and training for clients. Addaction staff advised clients about this service from the point of assessment. Addaction Stratford supported clients as recovery champions. This helped their recovery and helped inspire and motivate other clients. One recovery champion told us how Addaction had supported them through their recovery and how the role of champion had been pivotal in their recovery.
- The service was promoting hepatitis C testing and raising awareness of the risks. It had a dedicated hepatitis C co-ordinator.
- Treatment outcomes profiles (TOPs) figures for the service for the first six months of 2016 were above the national minimum of 80%, with figures being above 90% for most months. Treatment outcomes profiles measure change and progress in key areas of the lives of people being treated in drug and alcohol services.

Skilled staff to deliver care

- The staff team included project workers, volunteers, and recovery champions. There was a non-medical prescribing nurse.In addition, a nurse was available who worked between Stratford and the neighbouring service at Leamington.
- There was access to sessional doctors who ran two clinics a week. Doctors had undergone the Royal College of General Practitioners Certificate in the Management of Drug Misuse Part 1.
- All staff at the service received separate monthly management and caseload supervision. All staff at the service had received an annual appraisal. Nursing staff undertook clinical supervision. Both doctors at the service had undertaken revalidation within the last 12 months. Revalidation is the process by which alllicensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise in their chosen field and able to provide a good level of care.
- Records showed 100% completion in key areas such as equality and diversity, safeguarding children and adults, information safeguarding, and health and safety. Staff received training in infection prevention and control and Mutual Aid Partnership (group work where the service facilitated clients to support each other in recovery). The manager told us that figures for alcohol and drug awareness were below 50%, as staff had received this training in other forms. Data presented by the service recorded training in the monitoring of blood borne viruses and administering naloxone as only 42% of staff. Immediately following the inspection, the manager was able to confirm that that all project workers had received naloxone training, and that all staff had received blood borne virus training, either as e learning or as part of induction training. He felt the figures given to us had not reflected all the training that had taken place. The manager said that not all training, such as blood borne virus training, was mandatory, but that it was recommended. They agreed that the service might benefit from clearer monitoring of both mandatory and recommended training. Staff we spoke with were consistent in stating they received appropriate training and were able to demonstrate their knowledge and skills in discussions and interactions with clients.

- Staff were able to access specialist training. Clinicians told us they were able to pursue training as part of their professional development and to benefit the organisation.
- Induction for new staff included a detailed ten-day introduction programme. Staff we spoke with told us they had received a full induction programme that helped equip them for their role. One relatively new member of staff discussed how they were able to shadow other staff extensively until they had sufficient skills, knowledge and experience to work independently.
- The service was able to address poor performance promptly. We discussed an example that showed the service was able to support staff in a timely manner through supervision to help prevent performance becoming a capability concern. When necessary, the service was able to act promptly in disciplinary issues.

Multidisciplinary and inter-agency team work

- There were monthly multidisciplinary team meetings with representatives from each Addaction location in Warwickshire. These were held monthly at alternating services and were chaired by the clinical lead. The team considered specific high risk or complex cases issues. Staff could present cases, and the clinical lead would discuss these with them and the sessional doctors. Minutes of recent meetings showed the full involvement of clinical leads, with relevant professionals from other agencies being invited and involved.
- The team worked pro-actively with other agencies. An Addaction project worker was a dual diagnosis lead for the service in dual diagnosis, linking with the local NHS trust. Addaction staff contributed to local groups concerned with homelessness and begging. Within case files, we saw evidence of positive multi-agency working across a range of services including criminal justice, local authority safeguarding and the agency providing additional client support.. We also saw regular correspondence with the clients' GP and pharmacy services.
- The team had monthly team meetings. In addition, there were fortnightly development sessions. These included guest speakers. A recent speaker had shared learning on smoking cessation. There would also be learning sessions to discuss serious incidents, including deaths, safeguarding, and incidents, as well as relevant national issues.
- There was no daily team handover. As staff worked together in one office, they shared relevant information and concerns on an ongoing basis, as well as at team and clinical meetings.
- There was a hospital liaison worker based at a local hospital who was contactable primarily by phone or email. Their role included assessing patients who had attended hospital and been identified by staff as possibly having a drug or alcohol problem. The hospital liaison worker provided a transition and continuity of care when patients were discharged back in the community so they could access the Addaction recovery partnership service. The hospital liaison worker also provided a brief intervention to those who did not require or want a long- term service. This would include giving the person drug or alcohol harm reduction information and information on how to access services. They would contact the team if any client known to them had been admitted to hospital. They also provided training to hospital staff including student nurses about drug and alcohol issues. They attended a monthly meeting with a consultant and nurses from acute and accident and emergency wards to discuss how they could improve processes within the hospital and develop the role. As the role was a specialist role there was no cover provided when the worker was off work. There was an established protocol in place for hospital staff to fax referrals to the service at such times.
- The team had good relations with the local police. The manager gave examples of police support and co-operation, and how they understood each other's concerns and priorities.

Good practice in applying the MCA

- We reviewed 10 client records. All contained a confidentiality agreement and consent to treatment and to sharing of information.
- Staff assessed a client's capacity to understand information at assessment and at each further contact. Staff would ask a client to rebook an appointment if the

client was heavily under the influence of a substance and unable to understand and retain information. This was part of the client's agreement to access treatment through the service.

- Staff were able to demonstrate their understanding of issues relating to capacity, how these fluctuated and how they supported.

Equality and human rights

- The service worked within the Equality Act 2010. All staff received mandatory training in equality and diversity.
- The service was accessible to people from all communities. Being discreetly placed within a general healthcare unit helped reduced the stigma for anyone wishing to use the service.
- The service had a good relationship with local mental health services. The service was a founding partner of a dual diagnosis steering group and had a dedicated dual diagnosis lead. This person liaised with the local community mental health team to ensure that people with a dual diagnosis of mental health problems and substance misuse received support and treatment that met their needs.

Management of transition arrangements, referral and discharge

- Staff we spoke with were able to describe how they planned for discharge with the client and that they explained to clients how they could re-access the service, if needed.
- Staff worked with a local partner agency to enable clients to access further support once discharged from the service. A worker from this service visited weekly to meet clients.
- The service worked with a local youth substance misuse service in order to support 18 year olds to transfer to adult services. Addaction Stratford referred any prospective clients who were under 18 to this service

Are substance misuse services caring?

Kindness, dignity, respect and support

- Staff were caring and thoughtful in their approach with clients. Staff listened to clients and displayed warmth and understanding**.** Doctors in clinics we observed took care to ensure clients understood processes and reasons for treatments and shared in the understanding and desirability of outcomes.
- Clients in the service were very positive in their comments about staff. Comments cards we received were very positive overall, with nine being very positive, one being neutral, and one expressing some dissatisfaction with a doctor. Typical comments from clients referred to "fantastic and supportive staff" and "have always been treated with respect."
- Staff showed a good understanding of client need. Consistent factors in client feedback was how the staff listened, were supportive and were not dismissive. Clients spoke of being "listened to", "respected" and "supported" by staff.
- The service maintained records safely and confidentially. Because clients were accessing the service by stairs or lift that could lead to other destinations, entrance and exit to the reception area assisted confidentiality and privacy. Interactions in the reception area, which did not appear crowded during our visit, were discrete and did not compromise privacy and dignity.However, when clients used the needle exchange room, the door was left open, which meant they could be seen by anyone who was waiting nearby in the reception area. Staff told us that this was because the room was small and that closing the door would have meant there was an uncomfortably small space to deposit needles and pick up new ones. Staff told us that if any form of examination or prolonged discussion was required, then another larger room would be used. We observed someone using the room for needle exchange and saw it was a brief and unobtrusive transaction. No clients we spoke with mentioned needle exchange as an issue for privacy and dignity. Nevertheless, there was a potential compromise of client privacy and dignity. Following our visit, the manager raised the issue with staff and told us they all agreed to move the needle stocks into the clinic room. This room had not been used originally as clients wishing to use the needle exchange might have to wait for the clinic room to be vacant. The service no longer saw this as a major

concern, as needle exchange requests rarely coincided with clinic appointments, and there was a pharmacy downstairs where clients could exchange needles if they did not wish to wait.

- We also saw clients conferring with staff in the toilet area regarding the results of urine tests prior to the samples being disposed. On at least one occasion during our visit, the door remained open, although there was no need for it to be left open.The manager explained the testing procedure satisfactorily. They acknowledged that leaving the door ajar while client and staff were conferring compromised the client's privacy, dignity and confidentiality and they would remind staff this should be avoided.

The involvement of clients in the care they receive

- Clients consistently told us they were fully involved in discussions and plans regarding their treatment and care. Care records contained signatures from clients showing they had agreed recovery plans. There was less evidence of clients having a copy of their care plans. Clients we spoke with did not regard having a copy of their recovery plan as a priority. They felt the important thing was to be aware and involved in the discussions that helped their recovery. Clients told us of being involved. One comment from a client stated, "All my goals have been reached".
- Clients could access advocacy through a support organisation.

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

Access and discharge

- There was a range or referral routes. The service received referrals from GPs, social services, the criminal justice system or from clients themselves. The service did not have waiting lists; clients were seen as soon as possible. Clients who spoke with us and who gave feedback on comment cards were consistently positive about the service's ability to respond promptly to requests. "They give me help when I need it, and "helped me straight away" were typical of the comments we received.
- After an initial assessment, the service saw clients at the next available slot, which was would be within the week.
- When clients did not attend appointments, the service would follow up with a phone call and other contacts as required. This was detailed in the active re-engagement procedure, which gave clear guidance to workers on re-engaging with clients who missed appointments.
- The service operated Monday to Friday 9-5. It had recognised this caused potential or real difficulties for clients in employment and therefore offered a late service on Thursdays until 7pm. We saw people who had difficulty attending during 'normal' opening times using this time slot. The service had also started, in the past month, to have a clinic at this time for a trial period. The service planned to evaluate the use and success of this service in order to decide on its future viability.
- The service covered a wide area, with a dispersed rural population. Recognising it may be difficult for some users to afford or be able to get to Stratford regularly, the service had established outreach sites in Studley, Shipston-on-Stour, Wellesbourne and Alcester. These were open once a week. In addition, the service had discretion to reimburse travel fares of clients who travelled to the main office.
- Appointments ran on time. We had no negative feedback from clients about having to wait for scheduled appointments, or of appointments being cancelled.

The facilities promote recovery, comfort, dignity and confidentiality

- The Stratford site was situated in a general healthcare clinic. This meant clients were visiting an ordinary healthcare environment that was new, airy, and accessible. The service was on the third floor, accessed by lift or stairs, with a small waiting area next to an open, welcoming reception counter.
- There was a range of rooms in which practitioners could see clients. The small room used for needle exchange did not promote privacy and dignity, as the door could not readily be closed when an exchange could take place. The room was not central to the reception area, and we saw exchanges taking place discreetly. If examination or prolonged conversation was required, the client and staff member could use another room.

We had no adverse comments from any clients about the use of the needle exchange room. However, following our visit, the service has agreed to make changes to the use of this room, as detailed in the 'caring' section of this report.

- All other rooms supported people's privacy and dignity, and conversations in them could not be overheard.
- A range of information was available for clients. Information leaflets were available regarding opiate treatment, alcohol advice and complaints.
- Clients who had stopped using drugs and alcohol could become volunteers or recovery champions in the service. Clients we spoke to who had become recovery champions were very enthusiastic about the positive impact this had for them.

Meeting the needs of all clients

- There was disabled access to the building and access to a disabled toilet. The lift was tested and working. Stairs were available, but staff said most clients used the lift.
- We did not see any leaflets in reception for clients who did not speak English.However, staff had access to a library of information in other languages and were able these to use if required.
- The service could access interpreters and signers if required. The area had a very small percentage (2%) of clients whose first language was not English.

Listening to and learning from concerns and complaints

- Clients we spoke with knew how to make a complaint about the service if they were unhappy about any aspect of it.Some clients told us they had complained to the service informally and felt staff had responded to them appropriately. All clients we spoke with said they knew how to complain and were confident they would be responded to appropriately if they had concerns.
- Staff were aware of how to deal with complaints. In line with Addaction policy, they initially sought to resolve complaints informally.
- The service had received two formal complaints in the twelve months up until June 2016. None of these had been upheld and none had been referred to the Parliamentary and Health Service Ombudsman (PHSO). The manager informed us of one recent complaint that was ongoing.

Are substance misuse services well-led?

Vision and values

- Staff worked a in a way that reflected and promoted the organisation's values. Staff identified that they felt part of a strong and close team and enjoyed working within the team. Staff had high praise for their manager and team leader. Staff were familiar with the registered manager of Coventry and Warwickshire Addaction, who regularly visited the office.
- Staff we spoke with were passionate about their roles and showed knowledge and enthusiasm around supporting service users to achieve recovery.

Good governance

- Staff received mandatory training and were appraised and supervised.
- The team worked together in a positive, co-operative and supportive manner.
- Incidents were reported, staff de-debriefed as appropriate and incidents learned from to help improve services.
- Staff were involved in regular clinical audits. These included all aspects of medicines management, including prescribing and dispensing, infection control and audits of clinic rooms and stock.
- The clinical social governance group reviewed all clinical governance and performance matters in the service. They had overarching responsibility for clinical governance and ensuring services were safe, effective and evidence based, in line with national standards. Minutes of these meetings showed they examined and managed issues appropriately.
- All staff and volunteers had undergone a disclosure and barring service check. Fit and proper person checks were carried out at the service.
- Coventry and Warwickshire Addaction were subject to a payment by result contract and performance. This was

monitored by completion of treatment outcomes profiles and national drug treatment monitoring system. The team regularly achieved percentages well above the minimum targets.

Leadership, morale and staff engagement

- Staff sickness and absence rates were low**.**
- There were no reported cases of bullying and harassment. Staff told us they knew how to use the whistleblowing process if necessary, and felt able to raise concerns without fear of victimisation. One staff member told us "I am listened to – this is a respectful organisation".
- Staff morale was good amongst all staff who spoke with us. The manager acknowledged that an ongoing staff suspension had affected staff morale. Staff showed some concern about this, but otherwise they were very positive about their work and the team. They were positive and well motivated both in discussions with us and interactions with staff and clients.
- Staff gave us examples of training and opportunities to develop their skills. A team leader was also the hepatitis co-ordinator. Staff chaired team meetings on a rotating basis.
- We saw good team working, with staff helping each other with queries.

Commitment to quality improvement and innovation

- The service pursued strategies for awareness of and reduction of risks associated with substance misuse by publicising and organising events around such topics as Hepatitis awareness. They were pro-active in working with other agencies in areas such as dual diagnosis. The service employed a community engagement co-ordinator for the Coventry and Warwickshire district who provided training, presentations, awareness raising and built relationships with probation services, magistrates and clerks to courts. They also delivered training to carers of substance misusers receiving palliative carers. They also provided training and raised awareness of the effects of substance misuse amongst elderly people. They recognised the importance of outreach work in this respect, as this group might be more reluctant to visit Addaction premises.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that the dignity and privacy of clients is maintained, by ensuring doors are shut whenever interactions such as urine testing are taking place.
- The provider should ensure that rooms used for needle exchange are of sufficient size to comfortably allow exchanges to take place confidentially.
- Staff training data should clearly inform the service of staff training needs.