Addaction

Addaction St Helens

Quality Report

80 Corporation Street, St Helens
Merseyside. WA10 1UQ
Tel: 01744 766210
Website: www.addaction.org.uk

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information given to us by people who use the services, the public and other organisations, and other information gathered by CQC, including information from our 'Intelligent Monitoring' system where available.

Summary of findings

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Summary of findings

Overall summary

Addaction is a national charity which provides support to people to help them recover from substance misuse. Addaction - St Helens is commissioned to deliver pharmaceutical, psychosocial and recovery orientated interventions to help people recover from substance misuse. This is a community based service for adults.

We identified a number of areas of good practice. The service ensured that risks were assessed and managed in providing treatment to people and running the service. Testing and treatment for hepatitis C was offered on site. The service offered flu vaccinations to all those being prescribed medication as a substitute to their opiate use.

The environment was clean and well equipped. Staffing levels kept people safe and met people's needs. Incidents were reported, reviewed and lessons learnt were shared with staff. Comprehensive assessments were carried out in a timely manner. A psychosocial component was integrated into treatment for all people using the service. Staff were well trained and supported.

Staff were respectful to people using the service offering the appropriate level of support. Measures were effective to maintain confidentiality. Recovery plans reflected peoples individual needs but we did identify that on occasions, they could be more specific and detailed. There was good provision to support family and friends of those using the service.

There were no waiting times to access treatment. Peoples' diversity was respected and the service made provisions to meet individual needs.There was a clear process to investigate and feedback complaints.

Staff were aware of the organisation's vision and values. There was an effective organisational governance system. Staff felt well supported by managers and there was a commitment to improving the service. We did not identify any regulatory breaches on this inspection.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We found that:

- The environment was clean and well equipped.
- There were measures in place to protect staff and people using the service from avoidable harm.
- Staffing levels kept people safe and met their needs.
- There were effective tools in place to identify risks to people using the service, staff and the wider community.
- Identified risks were well managed. There were two daily meetings for staff to review risk and to keep staff updated.
- Addaction at St Helens had access to the social services database system. People using the service were checked on the system to identify any parental or contact responsibilities. This enabled additional support to be offered and/or safeguarding measures to be taken if necessary.
- Incidents were reported and reviewed. Lessons learnt were shared with staff.

Are services effective?

We found that:

- Staff assessed people's needs comprehensively in a timely manner.
- Staff tested and treated people for hepatitis C on site. This enabled people who had been found positive for the disease to receive their treatment in a familiar environment reducing missed hospital appointments.
- The service offered flu vaccinations to all those prescribed substitute opiate medication.
- The team integrated psychosocial components into treatment plans for people using the service.
- Staff were well trained and supported.
- The service had good links with other agencies to ensure the holistic needs of the person were considered. This was particularly good for additional health needs.

Are services caring?

We found that:

- Staff were respectful to people using the service and offered the appropriate level of support.
- The individual needs of people using the service were considered.

Summary of findings

- Measures were effective to maintain confidentiality.
- Recovery plans reflected people's individual needs.
- Recovery champions acted as advocates for others using the service.
- There was good provision to support family and friends of those using the service.

Are services responsive to people's needs?

We found that:

- There were no waiting times to access treatment.
- The recovery suite was co-facilitated by recovery champions. There was a good range of activities and these were accessible to all people using the service (unless under the influence of drink and drugs). This promoted recovery and independence.
- People's diversity was respected and the service made provisions to meet individual needs.
- There was a clear process to investigate and feedback complaints.

Are services well-led?

We found that:

- Staff were aware of the organisations vision and values.
- There was an effective organisational governance system.
- Staff felt supported by management and were confident that concerns could be raised without victimisation.

Summary of findings

Summary of findings

What people who use the location say

We spoke with seven people who used the service. Comments were all positive including:

- 'ten out of ten overall'
- 'staff are fantastic, very helpful and good at getting you to engage'
- 'staff very supportive'
- 'really good service but needs to be advertised more'
- 'staff - friendly and knowledgeable'

Areas for improvement

Action the provider SHOULD take to improve

The provider should ensure that interventions in all recovery plans are specific, measurable, achievable, realistic and timely (SMART).

Good practice

- There were two daily meetings for staff to review service user risk and update staff on those risks.
- Testing and treatment for hepatitis C was offered on site. This enabled people who had been found positive for the disease to receive their treatment in a familiar environment reducing missed hospital appointments.
- The service offered flu vaccinations to all those being prescribed substitute opiate medication.

Addaction St Helens

Detailed findings

Services we looked at:
Substance misuse services

Our inspection team

Our inspection team was led by:

Our inspection team was led by:

Helen Gibbon, Inspector, Care Quality Commission

The team included two CQC Inspectors, a specialist substance misuse nurse and an expert by experience.

Background to Addaction St Helens

Addaction is a national charity which provides support to people to help them recover from substance misuse. Addaction have been commissioned to provide substance misuse services for adults in St Helens since 2012. The service accepts self referrals from people who are concerned or experiencing negative effects from their drinking or drug use. It also takes referrals from external sources such as social services and the criminal justice system. It works in a shared care approach with 12 local GPs.

Addaction - St Helens is commissioned to deliver pharmaceutical, psychosocial and recovery orientated interventions to help people recover from substance misuse. The service provides injecting drug users with access to sterile needles, syringes and other equipment and the safe disposal of used needles and syringes. It also offers a 'breaking the cycle' project which works with the families of those using the services.

Why we carried out this inspection

This inspection is part of our piloting process for inspection community substance misuse services.

How we carried out this inspection

To get to the heart of 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?

We carried out an announced visit on 11 February 2015 to the Addaction - St Helens.

During the inspection visit, the inspection team:

- spoke with seven people who were using the service;
- spoke with the manager of the service;

Detailed findings

- spoke with nine other staff members; including doctors, nurses and recovery co-coordinators;
- attended and observed a daily risk meeting and a weekly recovery champion meeting.

We also:

• looked at seven treatment records of people using the service and

• looked at a range of policies, procedures and other documents relating to the running of the service.

Is the service safe?

Our findings

Safe Environment

The building was owned and managed by the local authority who have the responsibility of ensuring cleanliness, fire checks, lift checks, security and maintenance. At the time of our visit, the building was mostly well maintained, clean and clutter free. The provider also carried out daily health and safety checks of the premises. There were sluice rooms available for the safe disposal of urine samples however these were not the same standard of cleanliness as elsewhere in the premises.

The toilets for use by people using the service had fluorescent blue lighting with the intention of deterring risky injecting behaviour on the premises. There was antibacterial gel situated around the building and provision for the safe disposal of clinical waste. The fridge used to store medication was locked and had regular temperature checks to ensure medication was stored at the correct temperature.

Records showed that people using the service signed a behaviour agreement on induction into the service. There were panic alarms within interview rooms and individual hand held alarms were also available if staff had concerns. People using the service could be seen in a downstairs interview room which was visible to other staff members if required. Although staff informed us there were very few incidents of unacceptable behaviour from people, the service was located very close to the local police station and were assured of a fast response if necessary.

Safe Staffing

The staff mix included prescribing GPs, clinical staff, recovery co-ordinators, 'breaking the cycle' workers (family workers) and administrators. There were two vacancies at the time of our visit with proper plans to recruit to these posts through interviews booked for the following week. Sickness levels had dropped significantly from high levels when the service was initially commissioned in 2012 to minimal current levels.

Cover arrangements for leave, sickness and duty cover were discussed as part of the team's daily morning meeting. Information gathered from staff, people who used the service and records demonstrated staffing levels kept people safe and met their needs. Additionally, staffing levels allowed for advanced recovery co-ordinators working with people from criminal justice backgrounds to have smaller caseloads due to enhanced contact and complexity. The service did not rely on, nor require additional support from agency staff.

Assessing and managing risk to patients and staff

Staff discussed risks in two daily team meetings attended by all staff. The meetings were held at the start and end of the day and were managed effectively. The meetings enabled advance arrangements to be made to manage risks and ensure staff awareness. Risks discussed included:

- The expected attendance of people with a poor history of behaviour.
- The risks associated with people missing appointments.
- Concerns regarding care orders.
- People who have missed prescription collections meaning they were out of treatment.
- Daily clinic lists and concerns.
- Debrief for staff at end of day if required.

Effective tools were used to identify and manage individual risks of people using the service. These risk assessments were reviewed at a maximum of 3 months. However, changes in peoples circumstances would result in immediate reviews. People prescribed medication would have monthly reviews by the prescriber if they were at high risk due to current injecting behaviour, chaotic drug use, with mental health concerns or on high doses of medication. Safe storage of medication was discussed with people using the service who were prescribed medication and had children either living or regularly visiting their home. Leaflets were issued by their recovery worker and also discussed at medical reviews. Risks to the wider community were considered as part of the risk assessment process. We saw the service involve a HIV group to address risks associated by a person with the virus having unprotected sex.

Addaction at St Helens had access to the social services database system "first response" through a contractual arrangement. All people using the service were checked on the system to identify any parental or contact responsibilities. This enabled additional support to be offered and/or safeguarding measures to be taken if necessary.

Staff were trained in the safeguarding of vulnerable adults, children and young people. Staff were aware of what to

Is the service safe?

look for and how to make a referral. Training was mandatory for all staff through the organisation e-learning site. Good links were also evident with the local safeguarding authority who provided additional training.

Staff were compliant with medicines management training for the control of the prescriptions used to prescribe controlled drugs. Prescriptions were stored in a locked safe with systems to ensure accountability and an audit trail.

The service offers prescribing as a substitute to illicit opiate use. Substitute prescribing is used in order to:

- Reduce or prevent withdrawal symptoms.
- Provide an opportunity to stabilise drug intake and lifestyle while breaking with illicit drug use and associated unhealthy risk behaviours.
- Promote a process of change in drug taking and risk behaviour.
- Help to maintain contact and offer an opportunity to work with the patient.

Substitute prescribing can only be accessed in St Helens through Addaction or through the GPs that work alongside Addaction. Therefore effective measures were in place to ensure people were not receiving dual prescriptions from different prescribers for the St Helens area. This did not prevent a person from obtaining an additional prescription for substitute prescribing from elsewhere in the country. The risks associated with dual prescribing meant people may receive levels of medication above safe tolerance levels and also the potential for medications being accessible to others. There were currently no national controls in place to mitigate the risk of a people obtaining more than one prescription for the same thing from different parts of the country. Therefore this risk was outside the control of the service but the service did what it could to check that people did not receive dual prescriptions.

Reporting incidents and learning from when things go wrong

Staff knew what constituted an incident and how to report it. Staff were de-briefed at the end of day meeting following any incident; this would be immediate if the incident was serious. Incidents were reported within 24 hours through the arrangements as part of a national provider of substance misuse services. The manager attended a monthly risk meeting which included a review of serious untoward incidents. The organisation tracked incidents nationally for shared learning. Critical incidents were reviewed by managers across regions with lessons learnt being cascaded through team meetings, emails and policy updates.

As the service is not commissioned by the Clinical Commissioning Group, they were not permitted to attend the Local Intelligence Network groups (LINs), this is the local forum for sharing information and overseeing arrangements for controlled drugs and ensuring lessons are learnt.

Is the service effective?

Our findings

Assessment of needs and planning of care

Comprehensive assessments were carried out for new people entering into treatment with the service. These were done in a timely manner and included assessment of substance use both current and historical, physical health, risk factors, children's information and treatment history. The records we viewed showed a recovery focused approach. Recovery plans were regularly reviewed and were personalised and holistic. However interventions in recovery plans were not always specific, measurable, achievable, realistic and timely.

All information was stored on the organisation's bespoke database called 'Nebula' and also paper based records were stored in a locked room accessible to staff.

Best practice in treatment and care

National Institute for Health and Care Excellence guidance (NICE) was followed for prescribing medications. The service offered 'comfort packs' to those nearing the end of pharmaceutical interventions to reduce some of the physical effects of withdrawal. These were offered for a limited period. Relapse prevention medications were also prescribed in line with guidance.

Treatment for all people using the service involved a psychosocial component through regular key work sessions with a named recovery co-ordinator. The service ensured that a co-ordinated approach was used for those additionally requiring pharmaceutical interventions. This was done through three way appointments for the initiation of prescribing of medication and at reviews. These appointments were attended by the prescribing clinician, the recovery co-ordinator and the person using the service. This ensured both elements of treatment complimented the other.

Psychosocial interventions offered were evidenced based and in line with NICE guidance. The organisation had linked these interventions into the different stages of treatment defined by the National Treatment Agency. This guided the service to effective interventions throughout stages in treatment.

Staff completed physical health checks for people using the service as part of the comprehensive assessment and these were reviewed every six months. This included flu vaccinations for those prescribed treatment for opiate use. This group of people are at higher risk of developing chronic obstructive pulmonary disease. Testing and pre-testing consultations for blood borne viruses were included in health checks and reviews. The service carried out dry blood spot testing for early identification of possible hepatitis viruses. A fortnightly hepatitis clinic was held at the service. This clinic was delivered in partnership with the hospital to encourage and support people into treatment for hepatitis C. Liver function tests were done by the service for those commencing a treatment regime which including prescribed buprenorphine.

On commencement of all prescribed treatment, a person's GP was contacted requesting a summary of health. Additionally, following each visit, a letter was sent to people's GP. This letter noted details of their treatment with the service and recommended any additional needs. For example, the requirement of an electrocardiogram for those on high doses of methadone as per NICE guidance.

Staff carried out routine urine screens to identify substance use. Steps were taken to check the integrity of the samples provided using temperature testing. The toilets used by people providing the samples were designed in a way to ensure there were no possible places people could hide samples for use by others.

Changes and progress of people using the service were measured using treatment outcome profiles (TOPS). TOPS is a monitoring instrument developed by the National Treatment Agency to be used at the start of treatment and in care plan reviews and reported through the National Drug Treatment Monitoring System (NDTMS). Addaction organisationally had further developed this tool to enable more in depth reporting for the services provided.

At the time of our inspection NDTMS was off line and had been for some months. Public Health England hold the responsibility for gathering these statistics and through this providing data locally and nationally on those people successfully leaving treatment for drug and alcohol misuse. Although this data was unavailable, staff informed us that since taking over the service in 2012, successful discharges had improved significantly.

Clinical staff were involved in clinical audits to establish areas of improvement. This included regular audits of blood borne viruses, a benzodiazepine audit and an audit carried out in August 2014 on patient group direction medications.

Is the service effective?

The Strang Report (commissioned by the NTA) recommended wider social interventions are incorporated into treatment to support recovery outcomes. This report goes on to state that effective treatment must be integrated with peer support and mutual aid. The service had a dedicated floor used as a recovery suite. This suite had facilities to encourage social activities such as music. It included a computer suite enabling people to job search, bid for social housing properties and to take educational qualifications. The suite was co-facilitated by people who used the service and who were on their personal road to recovery. The service encouraged these people to become champions in recovery in their own communities, increasing mutual aid whilst also ensured they do not become service dependent.

Skilled staff to deliver care

The team comprised of a clinical lead, three qualified nurses as well as 22 recovery co-ordinators. There was a qualified nurse available at all times. The service also used sessional hours from two GPs to ensure responsive treatment. Staff told us there were no concerns around staff availability. Appointments and activities were not cancelled due to staffing issues.

We observed individual training needs analyses in staff records and were informed these were used in a planning day to identify training needs for the year. All staff received mandatory training in safeguarding and health and safety. Further training was then dependant on roles. The lead nurse was qualified to Royal College of General Practitioners certificate in the management of drug misuse part 2 and also due to qualify as a non medical practitioner. Recovery co-ordinators had received mandatory training including motivational interviewing, cognitive behavioural therapies and risk management and assessment. Most training was refreshed annually. There was a comprehensive e-learning library where additional training could be accessed.

Staff informed us that there were many opportunities for training and they were given time and support to increase their skills. One of the nurses was in the process of completing specialist training in wound care, the 'breaking the cycle' family worker had a level 4 foundation degree working with complex needs and had also completed foetal alcohol training and specialised domestic violence training.

The organisation's supervision policy stated that staff should receive no less than ten supervisions per year. Files we looked at showed us this was being achieved. Supervisions were structured including agenda points such as check in, conduct, team and action points. Previous supervision action points were reviewed. There was also group clinical supervision held every 6 weeks which discussed themes, incidents, complaints and feedback. The clinical lead had supervision monthly from the service and quarterly supervision with the organisation's clinical director. Staff also had the opportunity for many informal supportive conversations.

Staff received appraisal through an individual personal development plan which were set annually in line with both the organisation's and the service's objectives. These were reviewed throughout the year. There were monetary incentives to achieve set performance indicators.

Team meetings were held every six weeks and included all available staff. There were separate meetings monthly for volunteers and recovery champions. Staff were able to rotate roles in order for them to gain new skills. For example, an administrator was keen to learn how to process new referrals and the service facilitated a program for her to shadow this task.

Staff from the same disciplines had role specific meetings to share learning. For example, there were regional administrative meetings and also a psychosocial intervention network with leads in each area.

The clinical lead was supported to attend relevant conferences and also spoke at conferences specific to their area of interest, for example the national immunisation conference. The 'breaking the cycle' family worker also attended a national conference and attended 6 weekly meetings with other family workers throughout the organisation.

Multi disciplinary and inter-agency team work

We observed a well integrated team and were told that everyone helped each other in their role. The service had good links with other professionals as follows:

- The National Probation service worked from the building one day per week.
- On site sexual health clinic including provision for implants, emergency contraception and smears.
- On site midwife clinic.
- Good links with the tissue viability service.

Is the service effective?

- Co-ordinated hepatitis C clinic on site.
- Good links with the women's refuge.
- The breaking the cycle worker had daily contact with social services.

Although the service were involved in the local pharmacy network, there were no formal protocols in place to ensure communication. Pharmacies play a key role in identifying risks for those using the services that are on a daily supervised consumption regime of prescribed controlled drugs. People could be at higher risk of overdose if their tolerance levels drop due to missing doses. For people missing collection, it may be necessary for re-assessment or a discussion with the prescriber before further prescriptions are issued. As pharmacies are often the most regular contact for the person, they are therefore able to identify other risks from their general appearance. Staff informed us that there was informal contact however this was sporadic. More effective communication between the service and the pharmacies would assist in monitoring people's medication compliance and associated risks.

The service was involved in local multi agency safeguarding hubs. These included representation from the police, domestic violence services and other external agencies to provide a collaborative approach to mitigate the risks of people requiring interventions from different partners.

The service had arrangements in place with the local hospital to ensure good communication. This involved ensuring Addaction were notified if a person using their service was admitted into the hospital. Measures could then be taken to ensure a person's treatment programme could continue whilst people were in hospital and help ensure they were no breaks in treatment following discharge from hospital.

Good practice in applying the MCA

The organisation has made Mental Capacity Act awareness compulsory for all staff in 2015. Staff were in the process of completing this training during the period of our inspection.

Is the service caring?

Our findings

Kindness, dignity, respect and compassion

People using the service told us staff were engaging and encouraging. We observed staff showing a caring attitude and enthusiasm to help others whilst understanding their individual needs. They talked about people using the service in a respectful manner.

Measures were in place to protect people's confidentiality. Records showed us that people were made aware of confidentiality and any information sharing from the start of their treatment and signed agreements were in place.

Records were stored in a locked room on a second floor. The windows of this room were frosted further protecting people's confidentiality. There was a separate entrance for those wishing to access the needle exchange facilities. There was a curtain around the medical couch in the clinic room to promote dignity.

The involvement of people in the care they receive

Recovery plans were mostly holistic covering substance misuse, health and social needs. We were told by people using the service that they were well informed and given choices regarding their treatment. One person informed us that they were keen to give something back to the service. This was listened to and they now volunteer to help staff. Another person told us the service encouraged self-dependency in seeking treatment for hepatitis C but did support them at the level required with appointment reminders.

The recovery champions acted as peer advocates to others using the service. They met weekly to discuss suggestions and told us they felt involved in future initiatives.

An external agency provided a weekly drop in service to support the family and friends of those using the service.

Is the service responsive?

Our findings

Access, discharge and transfer

There were no waiting times into treatment to receive substance misuse support. New referrals were all received through a single point of contact, including self referrals and referrals through criminal justice staff or through other professionals. This prevented delays that could be caused if there were different access routes.

There was good access to the clinical team which allowed for required changes in medications to be made quickly. Appointments for these were generally made within five working days. However appointments could be offered instantly in emergencies. The nurses also offered a drop in clinic for unplanned health issues. This included clinics for wound care.

People coming out of local prisons who required substance misuse support were allocated through the single point of contact for referrals and followed the same process requiring a new comprehensive assessment. This ensured that their changing circumstances and needs were met. People being released from prison were notified about the service in advance to ensure appointments were made and the person did not have any gaps in their treatment.

People failing to attend appointments were discussed in the daily meetings. This allowed the service to put in place interventions to encourage them to re-engage. These measures could include liaison with their housing provider for example. If these measures were unsuccessful, a safe detoxification from medication would be planned with the clinical lead.

The service recognised that some people with substance misuse issues find it difficult to engage and maintain appointments particularly at varying locations. To overcome these barriers, the service offered additional support clinics on site to assist in attendance, for example, sexual health and midwifery.

The recovery centre was also available for those people accessing treatment through a shared care arrangement with their own GP.

The facilities promote recovery, dignity and confidentiality

On walking into the service there was a calm and friendly feel. The waiting area was welcoming with water available and a good selection of information and leaflets on display. This information included available groups, domestic violence services and other literature to ensure people understand some of the risks such as drug driving literature. However we did find that some of this literature was out of date.

Recovery champions (people who use the service and who were progressing well in their personal recovery journey), had the opportunity to manage the main front desk to the service. This meant that those entering the service would visibly see that there is a recovery focused approach.

There were adequate rooms for key working sessions and clinics. The recovery suite was on a separate floor and available to all unless people were obviously under the influence of drugs or drink. The floor had a kitchen for use by people using the service and vending machines containing snacks.

Art work from people using the service was displayed around the premises.

Meeting the needs of all people who use the service

The staff respected people's diversity and human rights. Attempts were made to meet individual needs including cultural, language and physical needs. Interpreters were available to staff if required.

The service opened late one night each week for those working daytime hours. This included a late night clinic each month. There was also Saturday morning opening. There was a lift in the service to enable people who used wheelchairs to access all floors including the recovery suite. The service ran groups specifically for women enabling a safe environment for relevant discussions. Information on different cultures and events were displayed on the notice boards however some of this information was out of date, for example advertising events that had already passed.

Outreach staff accompanied police walking around the locality. This encouraged engagement from new people and also from those who found attending the service difficult. The service had received a donation of free bikes from the local passenger transport authority. These bikes enabled recovery champions to support staff on outreach work to demonstrate visible recovery.

The service employed two family workers called 'breaking the cycle' co-ordinators. These staff worked with the whole

Is the service responsive?

family to prevent generational substance misuse and provide co-ordinated interventions impacting on someone's ability to address their drink or drug misuse. For example, involvement with schools and finances. All young people were referred to the Young Carers Centre for support specific to their needs.

Listening to and learning from concerns and complaints

Staff and people using the service were aware of the organisation's complaints policy. Complaints and compliments were collated monthly and reviewed both organisationally and at service level. The organisation's risk and incident lead analysed complaints to discuss and address any themes. These would then be shared with teams through emails and team meetings.

The service had received one complaint in the quarter we inspected. This complaint was being investigated.

Is the service well-led?

Our findings

Vision and values

Staff were aware of the organisation's vision and values. Staff had attended an organisation road show hosted by members of the senior leadership team. There were road shows nationally throughout 2013 and 2014 to ensure all staff in the organisation were aware of the strategic direction, the organisation's values and an opportunity to raise any concerns with senior leaders. Staff knew who Addaction's chief executive was and informed us that he attended the launch of the service in 2012.

The staff files we looked at showed that supervision was linked to organisational values. The individual personal development plans for each staff member detailed how individual objectives linked into organisational direction.

Good governance

There was a clear organisational governance structure and arrangements within Addaction - St Helens service. These arrangements included:

- Organisational training library and opportunities.
- Effective systems to report, investigate and feedback incidents and complaints.
- Role specific support, for example, administration, criminal justice, family work.
- Organisational shared learning and guidance.
- Organisational policies.

Although the service was supported by the national organisation's governance systems, the service manager had sufficient authority to develop the service locally with the understanding of the local area and need. Staff informed us that they felt well supported and involved both locally and as part of the wider organisation.

Leadership, morale and staff engagement

Addaction had been commissioned to provide substance misuse services for adults in St Helens since 2012. At the commencement of their contract, the service had high staff sickness levels, limited development opportunities for staff, low morale and a history of unacceptable behaviour from those using the service. Addaction undertook staff consultation and sought suggestions from people regarding expectations in order to improve the service overall.

There was evidence of clear leadership at St Helens with managers being visible and accessible. Staff were aware of the whistleblowing policy. Staff told us that they had no concerns about approaching management and felt completely supported. If concerns were raised, they were always responded to. All staff were proud about improvements the service had made. It was evident that the culture was positive and that staff considered Addaction to be a friendly organisation to be part of. Managers were well supported by the national organisation and were encouraged to develop service provision. The service manager was currently studying for a Masters degree in strategic leadership management to help further shape and lead the service.