Addaction - Coventry

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

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 issues that the service provider needs to improve:

- Nurses cleaned the clinic rooms however there was no rota for this or records to show how often they cleaned them. The service used one room for clinics, which was not fit for purpose as it had a carpeted floor, and no handwashing facilities, which increased the risk of infection.
- Not all areas of the building were clean and well maintained. The upstairs waiting area was unclean and the sanitary waste bin in the disabled toilet was over flowing.
- The needle exchange worked well however it contained out of date needles and syringes. We spoke to staff about this but it remained unresolved at the end of the inspection. It was not clear how staff audited this area
- Staff did not always update risk assessments with new information about a client's current situation. Recovery plans lacked detail and were not always recovery focussed. Staff did not always record a full history of a client's substance misuse. This made it difficult for staff to support clients when workers had periods of absence.
- The service used paper records, an electronic recording system, and personal files on the computer system to store records. Some paperwork

Summary of findings

was kept in staff drawers and pigeonholes. The system for storing paper records made it difficult to locate files and this could affect client's safety and care.

- The service was based in a large building set over three floors. The building was in need of some updating inside. The rooms did not have soundproofing and client conversations could be overheard. The needle exchange had a partially obscured window, which meant other clients could see inside. This meant the service could not maintain the confidentiality and privacy of clients using the service.
- The service did not provide separate facilities for clients with children within the building. If a client had to bring a child with them, they would wait in the reception area. This was busy and an area the service had identified as a potential risk.
- The service was not notifying the Care Quality Commission of incidents that required notification under their registration.

However, we also found the following areas of good practice:

- Staff received regular supervision and an annual appraisal. The records from these contained detailed action points. They covered a range of topics including case management and safeguarding.
- The service had built strong relationships with external organisations such as housing, local charities and the community mental health teams. This enabled clients to build support networks outside of the service giving them a holistic approach to recovery.
- The service provided a range of treatment options including one to one support, group therapy, and community detoxification programmes. They did not have waiting lists and clients could drop in for support.
- The staff had a good understanding of the needs of their clients and showed commitment and a passion for their work and the clients they supported.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services		see overall summary

Summary of findings

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Summary of this inspection

Background to Addaction - Coventry

Addaction Coventry is a community substance misuse service. As part of the local commissioning agreement, the service operates under the name The Recovery Partnership. It works closely with the Addaction substance misuse services in Warwickshire.

The local authority commissions the service and it covers all of Coventry. The service provides an outreach clinic and work with local charities to provide specific support for hard to reach groups such as sex workers.

Addaction has 63 contracts nationally providing a range of substance misuse services.

The service has open access for clients age 18 and over who have an issue with substance misuse. They provide a range of services for both drug and alcohol users including assessments, needle exchange, criminal justice interventions, prescribing, physical health checks, group support and one to one support.

They work closely with local community mental health teams to provide support to people with a dual diagnosis of substance misuse and a diagnosed mental health issue.

The service provides community detoxification and support to access inpatient detoxification and residential rehabilitation.

Addaction Coventry opens 9am – 5pm four days a weeks and 9am – 7pm on a Tuesday.

The service uses recovery champions who are ex-service users and volunteers to provide mutual aid partnership meetings, peer support and group sessions.

The independent advocacy service is specifically for clients with substance misuse issues and has a base within the service.

Addaction offer regulated activities in treatment of disease, disorder, or injury and diagnostic and screening procedures. The service has a registered manager.

The service was last inspected in December 2013 and met all standards. There were no compliance actions.

Our inspection team

The team that inspected the service comprised CQC inspector Linda Clarke (inspection lead), two other CQC inspectors, one CQC inspection manager, one CQC assistant inspector, a specialist advisor with knowledge of governance in a substance misuse service 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.

Summary of this inspection

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 this location, looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with 16 clients
- spoke with the registered manager, operational managers and the contracts manager
- spoke with 25 other staff members employed by the service provider, including nurses, project workers, doctors, community engagement workers and administration and reception staff
- spoke with the advocacy provider based within the service
- received feedback about the service from commissioners
- spoke with two volunteers
- attended and observed one group session and three clients one to one meetings and observed the reception area.
- collected feedback using comment cards from 10 clients and six staff
- looked at 17 care and treatment records for clients
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We received 10 comments cards from clients. Of these, six were positive and clients stated the service and staff had provided a supportive environment and had really helped them. Of the 16 clients we spoke to nine stated they felt safe within the service and two said they felt the reception area was unsafe. Five clients said there had been several changes of project worker and two said staff had not informed them about the changes. Nine clients said staff treated them with respect.

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 issues that the service provider needs to improve:

- Staff did not always fully complete risk assessments and risk management plans. They did not always detail changes in a client's current situation or add additional risks identified during one to one sessions.
- Clients often had to wait for over an hour and sometimes longer to see the duty worker as the system was not robust. Some clients decided not to wait and it was unclear if these individuals received a follow up if they did not come back.
- Staff used a room for clinics, which was not fit for purpose. It had a carpeted floor and no hand washing facilities. This increased the risk of infection.
- The needle exchange and storage cupboard contained out of date needles and syringes and it was not clear how staff audited this.
- Staff only partially followed the lone working policy for working in the community. The policy stated that a code word should be used by the service so a staff member could alert them if in difficulty while lone working. This was not in place and staff were not aware of this. They did not have a mobile phone each and had to rely on a shared phone being available. If the service continued to do more home visits this could be a potential issue for staff safety.
- Staff did not check if the external cleaning company were cleaning all areas of the building. Some areas were unclean and recording of cleaning of the toilets was not updated.
- The service had an evacuation chair on the third floor of the building but did not identify who was trained to use this.

However, we also found the following areas of good practice:

- Staff knew about the duty of candour and demonstrated this in being open and honest with clients when incidents happened.
- Equipment such as blood pressure machines were new and other equipment had been safety tested. The fridge used for vaccines was locked and had the temperature recorded.
- Staff received training including safeguarding children and young people level 3 provided by the NSPCC.

Summary of this inspection

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following issues that the service provider needs to improve:

- Not all clients had recovery plans and in those staff had completed they lacked detail and did not focus on a client's strengths and goals.
- The service had three methods for storing records. It was difficult to locate and access the paper records and staff would not be able to access these at short notice.
- The service used a recording tool for clients undergoing detoxification but this could not be personalised or give details of the interventions staff used.

However, we also found the following areas of good practice:

- Staff had worked closely with community mental health teams to develop a joint working dual diagnosis policy.
- The service had good links to external organisations such as housing and support with benefits and referred clients to them so that they received a holistic service. They worked with local charities to engage with hard to reach groups of clients.
- Staff demonstrated an understanding of the Mental Capacity Act and used this to support clients.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff knew clients well and treated them with dignity and respect.
- The independent advocacy service was based within the same building as Addaction Coventry allowing clients to have easy access to this service.
- The service trained ex clients to be recovery champions and volunteers to provide additional support to those using the service.
- Staff supported clients to give feedback and to make complaints and compliments.

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

- Staff had written recovery plans for clients who said they felt included in discussions about this however the plans did not reflect clients comments.

Summary of this inspection

- Staff leaving and delays in recruitment of new staff had affected continuity of care for clients. The service did not always inform clients about changes and some had experienced several changes of project worker.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following issues that the service provider needs to improve:

- The service was in an old building, which was in need of updating internally. Rooms are not soundproofed and conversations could be heard from the corridors. The needle exchange had a partially obscured window in the door. Clients waiting in reception could see in to this room. This meant staff could not ensure confidentiality for clients because of this.

However, we also found the following areas of good practice:

- The service provided a range of interventions including one to one sessions, group work and community detoxification. It was an open access service and clients could drop in to see the duty worker. The service did not have waiting lists as clients were allocated at a weekly meeting.
- The service provided group sessions to support the one to one work they were providing which helped to give additional support networks for clients.
- There was a wide range of leaflets and information available to clients throughout the building.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following issues that the service provider needs to improve:

- Staff felt disconnected from the wider Addaction organisation and saw themselves as part of the Recovery Partnership. This was the name given to the service locally by commissioners.
- Staff did not feel that senior managers listened to their concerns, as they did not receive feedback on the issues raised. Staff morale was low due to staffing shortages, recruitment issues, and increased caseloads.
- The service had not been providing the CQC with regular notifications as required as part of their registration.

However, we also found areas of good practice, including that:

Summary of this inspection

- Project workers received regular supervision and notes for these were comprehensive and included actions to be undertaken.
- Team leaders received additional management training to improve their skills and build confidence in managing the teams.
- The service was involved in two local schemes aimed at improving the wellbeing of the workforce.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Addaction provided an eight-module e learning training course in the Mental Capacity Act. Of the staff that had contact with clients, thirteen had completed this and the rest had started the modules and were due to complete this by September 2016.

Staff demonstrated an understanding of the act and gave examples of applying this through their daily practice. They felt this was particularly important when clients presented at the service in an intoxicated state. Discussion involves project workers, nurses, and doctors.

Staff discussed mental capacity during multidisciplinary team meetings and recorded this in the notes from the meeting.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

- The service had a camera and buzzer system to allow access to the building which was up a flight of stairs. The service used volunteers and recovery champions to greet clients and guide them to reception.
- A team of volunteers from another organisations charitable trust had redecorated the reception area. There was a manned reception desk, which was not screened. There were two waiting rooms and CCTV covered both areas although there was a small area, which the CCTV did not cover. The service had a high number of clients using this area and staff on reception felt overwhelmed at times. They reported being exposed to episodes of aggression between service users and did not feel equipped to manage this. Staff received an introduction to managing conflict training but this was not mandatory and only 13% of staff had completed this in April 2016. They had access to a panic alarm and had used this frequently. Managers acknowledged safety in the reception area needed improvement and staff required additional training. Procedures such as who to contact in the building for help and de-escalation techniques had been put in place to support this but staff still felt it was an area that did not feel safe.
- The service is set over three floors. Staff had panic alarms and there was a monitor box on each floor to indicate where an alarm was going off. A light flashed above the door of the room where the alarm had been triggered. Team leaders took responsibility for responding to the alarm call but their base was at the opposite end of the office to the monitor box. They also had to go through security locked doors to move around the building. Staff stated this had not caused delays in responding to the alarm calls. Staff used rooms that had mirrored glass panels in the door for privacy when working with clients.
- Clinic rooms were clean and tidy. Nurses cleaned these on a rota however; there was no cleaning record available to indicate how often this happened. Staff used a room upstairs for clinics. The clinical waste bin was stored in this room. This was not fit for purpose as it had a carpeted floor and no hand washing facilities. Equipment such as the ECG monitors and blood pressure machines were less than 12 months old, other equipment had been safety tested, and calibration of scales had taken place.
- The fridge in the clinic room was locked and nurses checked and recorded the temperature daily. In an incident before the inspection where the fridge appeared to not be working all stock was disposed of and reordered. All vaccines such as Hepatitis A and Hepatitis B and urine testing kits and oral swabs were in date. Emergency drugs, naloxone (used in cases of opiate overdose) and adrenaline (used if a client had a serious allergic reaction) were kept in a cupboard and were in date.
- The needle exchange worked well however it contained out of date needles and syringes. We spoke to staff about this but it remained unresolved at the end of the inspection. It was not clear how staff audited this area.
- Not all areas of the building were clean and well maintained. The upstairs waiting area was unclean. The sanitary waste bin in the disabled toilet was over flowing. In the toilets used for testing downstairs it appeared that cleaning of the plastic safety glasses had not taken place and there was no record of this happening. According to the cleaning schedule the toilets had last been cleaned a week

before the inspection although the service stated they were cleaned daily and this was an issue with the recording sheet. The service had a contract with an external cleaning company who cleaned the building five days a week but staff did not appear to check this took place. Addaction used an external company to dispose of clinical waste.

- The service had identified fire marshals. The fire safety posters indicated different meeting points, which would be confusing in the case of a fire. They had an evacuation chair on the third floor of the building but did not identify who was trained to use this. Staff tested fire alarms weekly and recorded this.
- Hand washing gel was available although some dispensers were empty and hand washing posters were on display.

Safe staffing

- The service had a range of staff including service and operational managers, seven whole time equivalent (WTE) team leaders and 39 project workers. The staff team included five nurses. One nurse was an independent prescriber and one a non-medical prescriber. Addaction had a lead nurse who worked across Coventry and Warwickshire.
- The average caseload for key workers was 45-50 cases. These were made up of a combination of prescribing and non-prescribing clients. Clients on a prescription required closer monitoring and appointments that were more regular. Non-prescription clients required lower levels of support. Staff reported that it was challenging to manage caseloads of this size and felt it affected the quality of the support provided.
- Staff assessed cases as they came in to the service through a duty system where a worker carried out an initial assessment. Workers had clients allocated to them at the weekly meeting so they had no waiting lists.
- Managers use a caseload management tool in supervision to review cases with key workers. This tool included dates for actions to be taken such as updating risk assessments.
- Addaction Coventry had 31 staff leavers in the last 12 months from July 2015 – June 2016. This included 21 project workers, an operational manager, a team leader, a doctor, administration staff, and two nurses. Nine of these had received an internal promotion and two had retired. Managers reported that recruitment to these posts had been difficult with two failed recruitment drives. At the time of the inspection they had successfully recruited to all posts and new staff were being inducted. This had added additional pressure to staff although agency staff who knew the service had provided cover. Clients reported continuity of care had been affected. Some clients reported they had experienced several staff changes often without explanation.
- The local authority commissioners reduced the budget for Addaction by 10% over two years from April 2016. This resulted in the loss of four WTE project worker posts. Managers stated this had not reduced the number of referrals but they had reviewed and increased their group work programme to manage this.
- The service used locum doctors and had a medical lead. Between them, they provided 5.5 sessions per week. Addaction Coventry had a shared care arrangement with local GP's. Shared care was an agreement between the service and the GP to provide treatment to the client in their own GP surgery. GPs made clinical prescribing decisions and team members from Addaction Coventry had a clinic slot to offer structured interventions. The worker would feedback to the GP on the client's progress so the GP was making informed prescribing decisions.
- Staff received mandatory training including safeguarding adults, infection control, equality and diversity, safeguarding children and young people and safeguarding information. Ninety six percent of staff had completed infection control training and 93% for safeguarding information.

Assessing and managing risk to clients and staff

- Addaction Coventry did not use a recognised risk assessment tool. We looked at 17 care records. Of these, one did not have a risk assessment and one was not fully completed. Staff had not updated the risk assessment in four files and although risk assessments were in place and updated in some cases the risks from disclosures in sessions did not follow through on to the risk assessments. When the assessments had been updated this often did not contain new information and changes in a client's circumstances. We saw one

instance where a safeguarding risk to a vulnerable adult had been detailed in the risk assessment but no actions had been taken and as a result, there was no risk management plan in place.

- Four out of the 17 files did not contain risk management plans and four had only basic information. The plans were not robust and did not always detail exactly how the service would manage the risks and the clients protective factors or own risk management. In one case a client had disclosed alcohol use during the initial assessment but his had not been addressed through key working and was not included in the risk assessment.
- Out of 17 files, 11 did not include plans for an unexpected exit from the service by the client. The service was using a mixture of paper records and an electronic recording system. Paper files were difficult to locate with no clear system and staff stated they kept some paperwork in drawers ready for filing or in personal files on the computer. Duty workers and agency staff would not be able to find files in an urgent situation. One worker told us they could not access notes when they took over cases after someone left suddenly as the information was in a personal file on the computer. In one case, a client was due to start a detox programme however the up to date risk assessment was not in the file and took several hours to locate as it was in a workers pigeonhole. It would have been unsafe to start the detox without it.
- The duty worker could see clients without an appointment if their needs changed. This system was managed by one worker and supported by another worker on an ad hoc basis when they were free. Clients often experienced a long wait and some clients chose not to wait but to come back on another day. We saw no evidence that there was a follow up of these clients if they did not return. The service also ran a third party duty system to see referral made by third parties such as the community mental health teams and GP's.
- Staff received level two vulnerable adults safeguarding training via e learning. Fifty-eight out of 65 staff had completed this in July 2016. Safeguarding children level 3 was delivered in partnership with the NSPCC and staff felt this face-to-face training was informative. Forty members of staff had completed this training and another session was planned for those who had missed it. Managers participated in a number of safeguarding workshops provided by Addaction nationally. In May 2016 staff were working with 80 cases where there was an open child protection case and had five open cases for vulnerable adults. Staff showed an understanding of safeguarding and understood the procedures for reporting. In two sets of records we looked at staff had not followed up on safeguarding issues which had been identified during assessment.
- Coventry had a multi-agency safeguarding hub (MASH). This multi-agency service includes staff fromhealth, social care, the police, education, and probation. Itcollates information from partner organisations to ensure all safeguarding activity and intervention is timely, proportionate, and necessary for keeping vulnerable children safe. The service made referrals to MASH but not all staff showed an understanding of its purpose or role within safeguarding.
- Staff saw clients at the base in Coventry or at an outreach clinic. Some staff including nurses made visits to client's homes. Addaction had a lone working policy, which staff used. Staff carried out Individual risk assessments before a home visit and a form with contact details were left with the team leaders. Managers asked staff to call the office at the end of a visit. If this did not happen team leaders would follow up with a call to the worker. Staff did not have a work mobile phone and had to use a phone from a shared pool of phones. There was not a robust system in place for staff to alert the office if they felt they were in danger during a home visit although the use of a code word was detailed in Addaction's lone worker policy the service was not following this.
- The service did not provide separate facilities for clients with children within the building. If a client had to bring a child with them, they would wait in the reception area. This was busy and an area the service had identified as a potential risk. Staff tried to see these clients at home or in a community venue when possible.

Track record on safety

- The service did not report any serious incidents in the 12 months before this inspection. They gave examples of learning from critical incidents including an attempted suicide which took place over 12 months ago by a client who had a dual diagnosis of mental health and

substance misuse issues. The incident identified that the dual diagnosis escalation protocol had not been used. This would have supported the client concerned to access mental health services in a timely manner. In response to this staff had completed work to make sure the protocol was embedded in working practice.

Reporting incidents and learning from when things go wrong

- The service reported 74 incidents from June 2015 to May 2016. The highest number recorded was 22 for service user deaths.
- Staff used an electronic system for recording incidents. Managers felt this had improved recording but numbers were lower than they would have expected. Incident reporting had been added to the induction programme and this training had been offered to permanent staff to improve the quality of reporting. All staff stated they knew what to report and how to do this.
- All incidents and complaints were analysed and reviewed monthly in Addaction's national critical incident review group (CIRG). Managers discussed items at these meetings and information was cascaded down to staff through team leaders to the project workers. Addaction also sent out case studies nationally on incidents, which included common learning and trends. Managers used these during supervision and at team meetings to aid learning.
- Addaction had introduced a clinical and social governance dashboard, which included incidents across the region and lessons learnt. Staff had access to this on the provider's intranet and the clinical and social governance newsletter and the CIRG feedback and learning bulletin.
- Managers and team leaders talked to staff following incidents and could refer them to the employee assistance programme provided by Addaction if they needed additional support. Three staff stated they did not feel they received a proper debrief or feedback following an incident.

Duty of candour

- Staff felt able to be open and honest with clients when incidents or mistakes happened. On one occasion when a prescription with the wrong date was handed out the staff member contacted the client, explained the reason for the error, and made sure it was corrected with the minimum disruption to the client.

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

Assessment of needs and planning of care

- We looked at 17 care records and pathway tracked two of these to understand the process used for assessing the needs of clients. Of these, 14 sets of records had recovery plans however only five of these were fully completed and detailed. Seven of the recovery plans were recovery orientated and looked at the client's strengths and goals but the information was basic. Staff did not record a full history of a client's substance misuse. In records for clients who had significant alcohol misuse staff did not consistently use the alcohol use disorders identification test (AUDIT) and in four files where it had been completed they had not completed the severity of alcohol dependence questionnaire (SADQ) as part of the assessment. Clients had not always signed recovery plans and there was no indication the client had been involved in writing them. In one set of records, we saw that a client had disclosed alcohol dependency but this had not been addressed through key working sessions and was not mentioned in the recovery plan.
- Records were not stored in an organised or accessible way. Some files were stored alphabetically while others were on shelves by individual desks. Staff were unable to locate specific files when asked and some paperwork was kept for filing in desks and pigeon holes. Staff also kept information in personal files on computers, which meant if staff left, or took leave other team members could not access this information. The service had a shared drive on the computer where they encouraged staff to keep additional information however this meant they used three systems made up of a computer file, an electronic recording system and paper files. Agency staff would find this system hard to use and it could compromise patient safety and care.
- Staff attended a rehabilitation panel chaired by commissioners to review clients for an inpatient rehabilitation service. Addaction Coventry completed

the assessments and presented the information to the panel. Clients could choose which service they wanted to attend and staff helped them to look at their options. Staff monitored these cases so that they could provide support to a client if the rehab did not progress.

Best practice in treatment and care

- Doctors, non-medical prescribers and the independent prescribers followed the National Institute for Health and Care Excellence (NICE) guidance when prescribing medication (Methadone and buprenorphine for the management of opioid dependence, NICE, 2007; DH, 2007; NICE, 2011). They also used the Drug Misuse and Dependence: UK guidelines on Clinical Management.
- The service provided community detoxification and Addaction had clear guidance and a pathway for this, which informed the interventions, provided. However, these were not translated in to care plans to share with clients. There was a document called 'detox care plan' but it was a recording tool for the withdrawal assessment. The plan could not be personalised to meet individual needs of clients and did not detail the interventions they could expect to receive. Staff recorded detox interventions on the electronic recording system but they were difficult to find.
- Staff stored prescriptions in locked rooms. The service had trained prescription administrators who printed prescriptions ready for doctors to sign, logged the prescription numbers on a spreadsheet, and ensured they were ready for patients to hand collect.
- The service did not store drugs on site except naloxone and adrenaline for emergency use. Staff were trained to administer naloxone.
- Staff considered physical health needs. They took alcometer readings to measure blood alcohol concentration and recorded blood pressure. Nurses provided electrocardiograms (ECG) to monitor for potential heart abnormalities for clients taking over 100ml methadone. Staff could also refer clients to their own GP for these checks to be completed.
- Staff offered clients blood borne virus testing for hepatitis and HIV. This was in accordance with best practice (DH 2007). The service also offered clients hepatitis vaccinations.
- Staff completed the treatment outcome profile (TOP) which measured change and progress in key areas of the lives of clients being treated in drug and alcohol services. Staff measured outcomes when clients entered treatment and every three months. When clients were discharged from the service, a final outcome measurement was undertaken. The service also provided information to the National Drug and Treatment Monitoring Service (NDTMS).
- Staff had been involved in audits for subutex (medication given to help with side effects when withdrawing from opiates) and liver function tests. The service completed an audit of clients using detox in October 2015 to understand the reasons why clients drop out of detox. Actions from this included reviewing the detox pathway and the guidance given to staff. Managers carried out a clinical management plan audit in January 2016, which looked at non-medical prescribing cases and how these had been managed.

Skilled staff to deliver care

- The team had managers, team leaders, project workers, nurses, and doctors. The project workers held all clients on their caseloads and nurses and doctors saw individuals depending on their level of need. Non-medical prescribers managed the prescribing for less complex cases but could refer back to doctors if needed. Project workers managed a mixed caseload of prescribing clients and those with a lower level of need. This did not allow workers to develop expertise or focus on either the drug related or alcohol related clients. Some workers felt being able to focus on a specific group of clients would improve the quality of support provided.
- Staff completed training to develop their skills including motivational interviewing and cognitive behavioural approach. Only 24% of the main staff team had completed motivational training and 11 staff out of 51 had completed cognitive behavioural approach training in April 2016. Staff could access training provided through Addaction's learning and development team if they identified a specific need although there was no evidence staff had taken this up.
- Addaction had a comprehensive induction for new starters who also attended the 10-week induction course for volunteers and recovery champions. This

covered topics including an introduction to safeguarding, mutual aid partnership training, confidentiality, and elements of recovery including recovery capital.

- Staff received monthly supervision. This was detailed and all personnel files we looked at showed it was up to date for project workers and team leaders. Managers' supervision was less frequent but the notes were detailed and thorough.
- All staff except new starters had received an annual appraisal. These had a lot of detail and contained action points.
- Managers addressed issues with staff performance through supervision initially. This was in line with Addaction's policy. If there was no improvement this was escalated to a formal process using Addaction's human resources department for support.

Multidisciplinary and inter-agency team work

- The service held monthly multidisciplinary team meetings. The medical lead, project workers, team leaders, and managers attended these. This allowed staff to discuss complex cases. They covered current situation, prescribing, risks, recovery plan goals, actions and possible outcomes. The notes from these meetings were detailed and robust.
- Staff reported there had been difficulties in the handover of cases as workers had left without much warning. New workers had taken on cases without a proper handover and lack of detail in notes had further complicated the situation and left clients at risk.
- Addaction Coventry had worked closely with community mental health teams (CMHT's) to develop a joint working dual diagnosis policy and procedure. Dual diagnosis is when a client has a diagnosis of mental health problems and alcohol or drug misuse. Dedicated team members from the service had a focus on developing this work and had created strong working relationships with local mental health teams. The service was part of the dual diagnosis steering group. Staff could talk with confidence about this work and gave case studies to demonstrate how it worked and benefitted clients.
- Staff made referrals to another voluntary sector organisation for housing and benefits advice and support. They had links with the Salvation Army, housing, the local hostel, and GP's. Staff from the advocacy service were based on site and were an integral part of the service.
- The service worked with the NSPCC to develop safeguarding children and young people training for all staff.
- A worker from Addaction Coventry was based with the family drug and alcohol court (FDAC). This project was funded by the department of education and Coventry city council to work with families whose children are subject to care proceedings because of parental drug and alcohol misuse.
- The service worked with two charities that provided support to sex workers. A project worker from the service attended their outreach sessions once a fortnight in the evenings to support this client group and provide access to substance misuse services. This client group would be unlikely to attend the clinic for appointments.
- The service had developed links with a local domestic violence and abuse charity. Staff members attended the multi-agency risk assessment conference (MARAC) to build awareness and understanding in this area.

Good practice in applying the Mental Capacity Act

- Staff received training in the Mental Capacity Act although this was not mandatory for this service. This was an eight-part e learning course. In July 2016 20%of staff had completed this training and the rest were working towards it and due to complete it in September 2016.
- Staff demonstrated a good understanding of the Mental Capacity Act through their working practices. They gave examples of clients who were intoxicated and decisions being made through discussions with clinical staff to not administer treatment as it would not be in the client's best interests at that time.
- Staff discussed mental capacity during multidisciplinary team meetings and this was noted in the minutes of these meetings.

Equality and human rights

- Equality and diversity was part of mandatory training. Eighty-eight per cent of staff had completed this training.
- The service did not discriminate against clients based on a person's sex, gender, disability, sexual orientation, religion, belief, race, or age. However, they did not provide specific projects for the lesbian, gay, bisexual, and transgender community.
- There was no specific support for black and minority ethnic groups and this included the large Polish community in Coventry.
- Leaflets on display were written in English however, the service had a welcome sign that had been translated into several languages. Addaction's website does offer a translation service where the content of the website can become accessible for people with visual impairments and is available in a range of foreign languages.

Management of transition arrangements, referral, and discharge

- Staff we spoke with described how they planned for discharge with the client .They explained to the client how they could re-access the service, if needed.
- Staff made referrals to other organisations for support with housing, employment, and benefits to ensure clients had a holistic support network.
- The service worked with the local youth substance misuse service in order to support 18 year olds to transfer to adult services.

Are substance misuse services caring?

Kindness, dignity, respect and support

- Staff treated clients with dignity and respect. During clinic appointments, we saw staff knew the clients well and had developed relationships based on trust.
- Patients had completed 10 of the 16 comments cards we received. Of these, six had positive comments about the service and the kindness and care shown by staff. Two gave mixed feedback and two were negative. This included a comment about the lack of continuity due to staff changes and five clients we spoke to out of fifteen also raised this as an issue.
- Staff demonstrated an understanding of the needs of clients and spoke passionately about the support they provided.
- One client reported there was not enough private space for clients who were waiting for staff to check their samples. They often waited in the communal reception area. Two clients reported that they felt unsafe in the reception area.

The involvement of clients in the care they receive

- Clients felt involved in their recovery plans however, these lacked detail, and staff had written them rather than clients. The community detox care plan was a recording tool involving tick boxes rather than a detailed care plan.
- Staff offered support to families and carers particularly those supporting a client going through home detoxification. They received information on what to expect and could speak to staff about any concerns.
- An independent advocacy service specifically for substance misuse clients was based within the service so clients could access advocacy, as they needed it. The advocacy service is an integral part of the service and its volunteers are actively involved in supporting clients.
- Clients were encouraged to become recovery champions or volunteers once they no longer required support. Recovery champions greeted clients at the door of the service and offered general and moral support. Volunteers supported the group work and participants were encouraged to become co facilitators with a staff member in future groups.
- Clients could give feedback on forms in reception or by using the suggestions box. A volunteer had recently collected a wide range of feedback, which had been placed, on a noticeboard.

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

Access and discharge

- Clients could refer themselves to the service, which had a duty worker available for people to drop in for appointments. This system had altered recently due to

staff shortages and had only one worker covering the duty rota with other workers helping on an ad hoc basis. This meant clients often had to wait an hour or more to see a worker. They had a system for seeing third party referrals so that clients could be seen promptly. These referrals came from community mental health teams, GP's, housing, Salvation Army and the local authority.

- The duty worker could take telephone calls and give general advice over the phone. Staff on reception also took calls but this area was open to people waiting and there was an issue in that other clients could hear confidential information.
- The service was open to anyone with a drug or alcohol misuse problem who was aged over 18. Young people had their own service provided by another registered charity. The service provided support to people in the criminal justice system and those leaving the prison system. We observed a client who had been released from prison coming in to access his prescription and due to the liaison between services; this had been a smooth transition for them.
- The service did not have waiting lists. Clients received an assessment and were allocated to a worker at the weekly allocations meeting. Clients could access the outreach service if they preferred. Staff did home visits if a client was unable to access the centre due to physical health needs or a disability. The service held one two-hour evening clinic a week for people who work.
- Clients could access group and peer support through the service. This included the women's group, self-build group, mindfulness and mutual aid participation groups.
- It was mandatory for new clients to attend the recovery choices group. This group explained what clients can expect from the service, gave an overview of treatments and groups on offer, and set out how a client can complain or give feedback. The advocacy service attended this group so clients were fully aware of this service and the support they offer.
- The service had a re-engagement policy. Staff used text messages and phone contact initially and contact through pharmacists for prescribing clients. Pharmacies flagged up if a client failed to attend so the prescription could be suspended until contact had been made. High-risk clients would also receive a home visit.
- The 'did not attend' rate for this service was 24% in the 12 months up to April 2016.The service had 806 planned discharges from the service and 241 unplanned exits when clients had not completed treatment during the same time frame.
- Clients stated appointments had been cancelled and rescheduled and of the 16 people we spoke to four told us that they had numerous changes of worker. Staffing shortages and issues with recruitment meant staff had high caseloads and it was difficult to provide cover during staff absence.

The facilities promote recovery, comfort, dignity and confidentiality

- The service was in a large building set over three floors made up of numerous rooms. It was an old building, which the service rented. It was in need of updating, as the decoration was tired and scruffy.
- The service had a wide range of rooms for group work and one to one sessions however; these were uninviting and did not promote a feeling that the service valued their clients. Some rooms had many windows and external noise from the city centre was very loud at times. The rooms were not soundproofed and people could hear conversations from the corridors therefore confidentiality could not be maintained.
- The needle exchange had a window where it was possible to see inside the room while in use which meant it was not private or confidential.
- The service had a range of information boards with leaflets about advocacy, mindfulness, groups, service user involvement and a national organisation supporting families affected by drugs and alcohol. Clients received information about treatment on an individual basis. Clients receiving detoxification had an information sheet detailing what to expect and information was given to the carer to ensure they fully understood the possible side effects.

Meeting the needs of all clients

- The service had a lift but if this was out of order someone with a disability would be unable to access the building but staff would do home visits. The service was located in the city centre and was accessible for clients using public transport.

- Clients could request leaflets in a different language or people could access the Addaction website, which had a translation facility.
- Addaction used an external service to provide interpreters for clients where English was not their first language and signers for the deaf community. Staff said they could access them easily when they needed them for appointments.

Listening to and learning from concerns and complaints

- The service had received 22 complaints for the six months from January 2016 to June 2016. Of these two were upheld, eight were partially upheld and seven were not upheld. Five complaints were still under investigation. Managers' added complaints to a spreadsheet however, this did not allow for the tracking of any actions taken. Operational managers investigated complaints and discussed these in management meetings. Managers recorded actions in the notes from these meetings. The clinical and social governance group review complaints and passed learning and actions to the team through the team leaders.
- Staff stated clients knew how to complain and they would support them with this if required. Clients said they had received this information. They could also give feedback via the suggestions box in reception. A board in the reception area displayed feedback given by clients to a volunteer. This was a new initiative and at the time of the inspection, Addaction Coventry had not posted any responses to the comments made.
- A common theme in recent complaints was about the change to prescribing where clients will now have to collect their prescription from their project worker rather than them being sent to the local pharmacy. Managers felt the benefits of this would be better client engagement, create routine for clients, and give staff more opportunities to review risk.
- In a complaint received via a third party organisation it was identified that a relative had not received satisfactory information about the loss of tolerance following detoxification. The service partially upheld this complaint as information given out was not specific enough. The service updated the information to show more detail and added a box to confirm staff had discussed it with clients and relatives.

Are substance misuse services well-led?

Vision and values

- Addaction's values are to be passionate, determined, and professional. Staff demonstrated this through their support of clients and dedication to encouraging them to make positive changes in their lives.
- The team members we spoke to were committed to working for The Recovery Partnership but generally felt disconnected from the wider Addaction brand. Some could name senior Addaction staff but stated they did not visit the service or understand the issues they faced.

Good governance

- Staff received mandatory training and managers encouraged staff to complete this. Much of the training including safeguarding vulnerable adults was e learning and staff did not find this aided their learning.
- Project workers and team leaders received regular supervision and an annual appraisal. These were thorough and detailed. We reviewed five personnel files. All were up to date and in good order. Managers did not receive supervision as regularly as their teams.
- Staff stated that using more than one system for recording clients' information added to their workload. To maximise time with clients they did not always complete filing or updating of records promptly or in detail. Staff shortages had led to increased caseloads and staff felt administration tasks were not a priority.
- Incident reporting was low and staff were being supported to understand what they should be reporting. Addaction Coventry had not been providing CQC with regular notifications as required as part of their registration.
- Staff learnt from incidents and complaints and gathered service user feedback but the service did not always use this information to improve the service.
- Staff followed Mental Capacity Act procedures and considered capacity when assessing clients. Staff had received safeguarding training but did not always recognise the significance of issues when working with clients and did not follow them up.

- Addaction in Coventry and Warwickshire were subject to a payment by result contract. Performance was monitored by local authority commissioners and formed part of their key performance indicators. These included two main areas, clients who had left the service but then came back for further treatment and those where a client had completed the course of treatment and was successfully discharged. These were split into three groups' opiate users, non-opiate users, and alcohol misuse.
- Staff individual performance targets had been set around supervision, attendance at team meetings, and treatment outcomes profile compliance (minimum of 95% of whole caseload). Staff were meetings these targets.
- Managers had control of their financial budgets. They reported that this had given them autonomy to do their job. They had support from an administration team.

Leadership, morale and staff engagement

- Sickness and absence rates were 6.88% of 65 substantive staff for the 12-month period to April 2016.
- Managers reported no cases of bullying and harassment within the service.
- Staff knew how to use the whistle blowing process and said they would use this if they needed to.
- Staff felt able to raise concerns with their immediate line manager and felt listened to however they did not feel senior managers acted on the issues raised, as they did not receive feedback. One staff member said they had been involved in an Addaction audit, which had been useful but never knew the outcome or actions from this.
- Staff morale was low. Staff gave a number of reasons for these including staff shortages, managers not appearing to listen or take action, performance issues being managed by sending emails to the whole team rather than with specific individuals and a culture of blame where they felt unable to raise their concerns with senior management.
- Some staff had been through the Transfer of Undertakings (Protection of Employment) regulations (TUPE) twice during the period of the current contract due to the breakdown of partnership working with another organisation. Staff found they were on different terms and conditions throughout the service, which added to the feelings of negativity. Managers had put on a wellbeing workshop and developed a staff forum. They had also started regular short weekly meetings so staff received regular face-to-face updates rather than communication by email which had started to improve morale.
- Senior managers had identified that team leaders would benefit from management training so they would be better equipped to support their teams. They were receiving institute for learning and management (ILM) training level 3.
- The main team of project workers were based in a large open plan office with a windowed office for team leaders at one end and the operational mangers office at the other end. Staff related well to each other individually but did not show that they worked as a team. Work such as updating of risk assessments was passed from nurses to project workers who already felt overwhelmed by their caseloads. Project workers stated that new staff coming on board would help but felt concerned about their ability to do the job. New team members reported they felt welcomed and supported during their induction.
- Staff spoke to patients if incidents happened or mistakes were made and all that we spoke to felt confident and supported to do this.
- Staff could give feedback through the staff forum and supervision. Addaction provided an 'ask Simon' system to allow staff to feedback comments to the senior team. Managers felt they could contribute to the development of the service and to the wider organisation.

Commitment to quality improvement and innovation

- The service had introduced a range of gold standards treatment packages to support their work. This came in three levels of low, moderate, and complex cases and would ensure managers could audit the quality of the support provided. It gave a clear pathway to workers about assessment, the number of sessions and the tools to use such as motivational interviewing. The standards cover topics such as cannabis use and opiate use.

Substance misuse services

- Addaction had carried out three internal quality audits from December 2015 to January 2016. Two of these followed a whistleblowing concern raised with CQC and a comprehensive action plan resulted from this.
- Managers had been involved in the 'yellow hats are not just for builders' workshop which offers practical guidance for developing the emotional strength and wellbeing of the workforce.
- Managers in the service were completing the Coventry city council wellbeing charter, which was an opportunity for employers to demonstrate their commitment to the health and well-being of their workforce. It involved using a self-assessment tool and gives access to a range of resources.

Outstanding practice and areas for improvement

Outstanding practice

- The development of the dual diagnosis policy and protocol with community mental health teams gave clients improved access to mental health services and had increased the knowledge of staff in both organisations through shared training. Mangers had given staff dedicated time to work with these clients and act as a liaison so that communication is clear and effective.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure all rooms used for clinics are appropriate for this use to prevent the risk of infection.
- The provider must ensure robust systems are in place for the storage and accessibility of records to maintain patient safety.
- The provider must ensure the confidentiality of clients can be maintained while receiving support.
- The provider must ensure risk assessments and risk management plans are fully completed with details of risk and client circumstances so that clients care can be supported by all staff.
- The provider must ensure regular audits of the needle exchange are carried out.
- The provider must send notifications to CQC as set out in the registration of the service.
- The provider must ensure there is a suitable waiting area available for clients who have children with them.
- The provider must ensure it has a plan in place for monitoring the external cleaning contracts for the building.

Action the provider SHOULD take to improve

- The provider should review the duty system to ensure clients don't have long waiting times in the reception area and ensure they follow up on clients who are unable to wait.
- The provider should ensure the implementation of the lone working policy ensures the safety of its workers.
- The provider should ensure all clients have recovery plans that are focussed on recovery, goals, and strengths and include input from the clients
- The provider should make sure recording tools for clients undergoing detoxification in the community are personalised and detail interventions used so these can be managed and audited.
- The provider should ensure they have a plan in place for informing clients when a worker leaves the service or is on extended leave.
- The provider should find ways to re-engage with its staff and support them to feel a part of the wider Addaction organisation.
- The provider should work with staff to address the issues of low staff morale.
- The provider should ensure that staff are trained to use the evacuation chair and those who have completed the training are clearly identified.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Interview rooms were not soundproofed and conversations in one to one sessions and during group work could be heard from the corridor. The needle exchange door was next to the reception desk. It had a partially obscured window however people could still see in to the room when standing in certain places. Staff could not ensure that clients dignity and privacy was being maintained. This is a breach of Regulation 10 (1)(2)(a)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risk assessments and risk management plans were not fully completed with details of risk and client circumstances. The service used a room for clinics, which was not set up for this purpose. It had carpeted floor and no handwashing facilities increasing the risk of cross contamination and infection. The needle exchange contained out of date needles and syringes which posed a risk to clients safety. The service did not provide separate facilities for clients with children which meant they waited in a busy waiting area in reception. This is a breach of Regulation 12 (1)(2) (a) (b)(d)(e)(h)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Not all areas of the building were clean and well maintained. The upstairs waiting area was unclean and the sanitary waste bin in the disabled toilet was over flowing. This is a breach of regulation 15 (1) (a) (c)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service used three methods for storing records, paper, electronic and in personal files on the computer. The systems were not coordinated. Paper records could not be located and the storage system was difficult to follow. Staff kept filing in drawers and pigeonholes. This was a risk to client care and safety. This is a breach of Regulation 17 (2)(c)(d a, b)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The service was not notifying the Care Quality Commission of incidents that required notification. This is a breach of Regulation 18 (2)