Addaction - Chesterfield

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:

- The service although reporting incidents and safeguarding internally had not routinely notified the Care Quality Commission (CQC).
- We found the quality and completeness of records we reviewed varied. We found one recovery plan was from a previous episode of care and dated 2014. Two records did not have current risk assessments. Of the 15 records we checked only three records contained a plan should a client leave treatment early. One record did not contain an assessment of alcohol use or contain a record of staff providing advice on harm reduction. The inconsistencies within the records and lack of detail could have put clients at risk.
- The client area in the Chesterfield office was poorly soundproofed. Conversations between people could be overheard from room to room. The service had a radio to try to manage this but conversation could still be overheard. Viewing panels were present in doors, which meant clients could see each other. This meant that the service did not maintain client confidentiality.

Summary of findings

- Access to the Chesterfield office was limited for wheelchair users or clients with mobility issues. Toilet facilities were on the second floor and shared with the staff team. There were no toilet facilities on the ground floor.
- Staff did not monitor the waiting area. Two clients told us they would feel safer if CCTV was in place. We saw children accompanying clients to appointments, although the staff were trained in safeguarding adults and children, the service did not have a protocol or policy in place for children visiting the service. Clients and children could have been at risk, as staff did not monitor the waiting area.
- There was a cleaning contract. However, there were no cleaning records to demonstrate cleaning of the building. Chairs in the waiting room were fabric covered which would have made them difficult to clean. This could have been an infection risk.
- Not all staff provided clients with information on how to make a complaint. This could have meant clients who were dissatisfied did not know how to raise this. Staff were not familiar with advocacy services this could have put clients at a disadvantage if they needed support. Most staff had not received training in the Mental Capacity Act although this was planned.
- The national target for the service to carry out an assessment of clients is within 15 days of referral. Over 40 % of clients waited longer than this time for an assessment. Waiting lists varied across the different areas that the service covered. Staff reported due to an increase in referrals and changes to practice the service was under pressure.

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

- The team had regular team meetings. Staff discussed learning from incidents and complaints. Staff received de-brief following serious incidents. They received an annual appraisal and regular supervision. The service manager identified staff training needs and development opportunities. Staff received the training needed to complete their jobs. Staff had a good understanding of their role in safeguarding clients, helping to keep clients safe. The service manager planned for staff leave helping to ensure the service had sufficient staff to operate safely.
- The team took account of national guidance to support their practice meaning that clients received care in line with best practice. Nurse prescribers received supervision with a medical practitioner helping to keep their practice safe. They felt supported by this. The service had inclusion criteria for clients but it was not so rigid that it excluded a client who could potentially benefit from the service provided. Staff used outcome measures to monitor client progress. The service actively targeted client groups who did not freely access the service such as pregnant women.
- Staff were warm, friendly, and relaxed when interacting with clients. Clients said staff were respectful and professional and never judged them. Clients were universally positive in their feedback about staff and the service they received. Clients were active partners in planning their care. There was a good range of information readily available to support clients.
- The staff team were a happy team. The team felt they had good relationships with each other and were supportive of each other. The staff felt their line managers were approachable and supportive.
- The service had governance systems in place. The service had developed two local protocols to meet the needs of their service and locality. There was open communication with local commissioners and other partner agencies.
- The service was visibly clean and carried out regular health and safety checks to ensure it was safe for clients and staff to use.

Summary of findings

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Addaction - Chesterfield

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Summary of this inspection

Background to Addaction - Chesterfield

Addaction Chesterfield provides a community service to people in Derbyshire who have alcohol problems. The service provides community detoxification services and one to one advice, treatment and support. It provides a prescribing service. The service is based in Chesterfield and has additional staff offices in Derby and Glossop as the service covers a large geographical area. The service operates Monday to Friday, usually between 9 am and 5 pm.

The service was commissioned for a 3-year period from April 2013 until March 2016, then extended for a further year by the local commissioning team responsible for substance misuse commissioning for Derbyshire County Council. The service commissioned was based on predicted client use. The Care Quality Commission regulates Addaction Chesterfield to provide the treatment of disease, disorder, or injury. The registered manager for the service is Laura Caryl, she is also the service manager.

We previously inspected this service in June 2013. We found they needed to improve the information they held in relation to workers who had joined the service from another provider. When we checked in October 2013, the service had made the necessary improvements.

Our inspection team

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

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, asked other organisations for information, and gathered feedback from staff members in response to an email we asked the provider to send to them.

During the inspection visit, the inspection team:

- visited the main staff and client base and visited two other staff bases, looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with nine clients

Summary of this inspection

- spoke with the registered manager and the team leader
- spoke with seven other staff members employed by the service provider, including nurses, project workers and an administrator
- received feedback about the service from the service commissioner
- accompanied staff members on five home visits including a home detox
- collected feedback using comment cards from 16 clients
- looked at 15 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 spoke with nine clients and received 16 client comment cards. Feedback we received was positive about the service provided. Clients felt staff treated them with respect and upheld their dignity. They felt they were active partners in their care. Clients felt listened to and staff supported them. They felt staff gave them enough information to make informed decisions. They felt staff offered them advice in a timely manner. Clients felt the staff cared about them and staff worked with them to identify treatment plans and goals. Generally, clients felt safe and they felt staff maintained their confidentiality.

Local commissioner feedback for the previous 3 months (May – July 2016) showed 80% satisfaction with the service provided. During the month of July 2016, 100% of clients were satisfied with the service they received.

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:

- The service although reporting incidents and safeguarding internally had not routinely notified the Care Quality Commission (CQC).
- We checked 15 records, only three clients had an unexpected early exit care plan present to detail actions staff should take. Two records did not have current risk assessment. This could have posed a risk to client care or staff members.
- Staff were not present in the waiting room and CCTV did not monitor the area. Two clients told us that they would feel safer if CCTV was in place. We saw two children visiting the premises with clients. The service did not have a local policy or protocol for children visiting the premises. Clients and children could have been at risk.
- There was a cleaning contract. However, there were no cleaning records to demonstrate cleaning of the building. Chairs in the waiting room were fabric covered which would have made them difficult to clean. This could have been an infection risk.
- Staff did not consider ligature risks in client accessible areas.

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

- The service main base was visibly clean. Regular health and safety checks and audits took place to ensure it was suitable for clients and staff. Staff kept prescriptions safely and regularly audited to ensure there were none missing.
- Staff had a good understanding of safeguarding concerns and made referrals when necessary. Staff knew what constituted an incident and reported this. Staff received de-brief following serious incidents.
- Regular team meetings took place. Staff discussed learning from incidents and complaints. Once the team identified learning, they developed action plans to improve the service.
- The team had developed local procedures to meet their needs and had robust processes to ensure lone-workers were as safe as possible. The service manager kept records of emergency contacts for staff members.
- The service manager used a tracker to manage planned leave. This helped to ensure sufficient staff were in work on a day to day basis. The service did not use bank or agency staff.

Summary of this inspection

- Staff completed mandatory training but had not updated the training matrix on the day of our 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:

- We found the quality and completeness of records we reviewed varied. We found staff had not fully completed three records at the point of assessment. Staff had not completed an assessment of client alcohol dependence. Staff had not assessed client motivation or provided advice on harm reduction. We found one recovery plan was from a previous episode of care and dated 2014.
- Staff had minimal knowledge in relation to the Mental Capacity Act (MCA). Three staff had received training in the MCA. The provider had recently introduced MCA training remaining staff had yet to completed it.

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

- The service followed national guidelines in the interventions it offered. We saw a detailed community detox plan that was thorough and comprehensive, helping to keep clients safe. We saw staff reviewed client's physical and mental health routinely during appointments. Staff kept client records safely and securely maintaining confidentiality.
- The service had three non-medical prescribers who received six weekly supervision from a local medical practitioner. The prescribers felt supported. Another nursing staff member was working to complete her non-medical prescribing qualification. The non-medical prescribers completed a risk assessment prior to issuing prescriptions to clients, helping to keep clients safe.
- Staff received an annual appraisal, with a six monthly review. Staff received supervision every four or six weeks combined with caseload management. Staff completed training in psychological approaches to work with clients. We saw staff employing techniques, such as goal setting and motivational interviewing during the interventions we witnessed.
- The service had clear inclusion criteria. Although the service had criteria, this was not so rigid that it excluded clients who could potentially benefit from the service. The service used treatment outcome profiles to monitor client progress.
- The service had established relationships with local services such as GPs, mental health services, recovery services, and

mutual aid organisations. The local commissioner had an on-going relationship with the service, information sharing was good. Established relationships helped clients to experience a smoother transition between services.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff were warm, friendly, and relaxed. Staff had a professional, respectful, and non-judgemental approach towards clients.
- Feedback from clients was positive regarding the service they had received. Clients felt listened to and supported. In recent service satisfaction feedback from May to July 2016, 80% of clients were satisfied with the service offered. Feedback for July 2016 was 100% client satisfaction.
- Clients reported they were active partners in their care. They stated staff offered them advice that allowed them to make informed decisions.

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

- Within records we checked we found no evidence indicating staff had offered clients copies of their care plans. Clients we spoke with did not have copies of their care plans.
- Staff were not familiar with advocacy services this could have put clients at a disadvantage if they needed support.

Are services responsive?

We do not currently rate standalone substance misuse services.

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

- Staff did not assess over 40% of referrals to the service within the agreed timescales. The service manager had taken measures to try to improve this but it remained an issue particularly in the Chesterfield area. Staff reported feeling under resourced due to an increase in referrals and changes to practice.
- The client area in the Chesterfield office was poorly soundproofed. Conversations between people could be overheard from room to room. The service had a radio to try to manage this but conversation could still be overheard. Viewing panels were present in doors, which meant clients could see each other. This was a risk to the confidentiality of clients using the service.

Summary of this inspection

- Access to the Chesterfield office was limited for wheelchair users or clients with mobility issues. Toilet facilities were on the second floor and shared with the staff team. There were no toilet facilities on the ground floor.
- Not all staff provided clients with information on how to make a complaint. This could have meant clients who were dissatisfied did not know how to raise this.

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

- Staff offered clients a choice of appointment times and venues to meet client needs. Generally, appointments ran on time, if staff were late, they rang to inform clients. Clients had a central contact telephone number. Clients could use this for advice, support, or to leave messages. Clients said staff always responded to messages they left.
- Staff had developed a new more assertive way of working to try to re-engage with clients who left the service prematurely. Staff knew the processes to follow for clients who did not attend.
- The service identified and targeted client groups who were not using their service, as they would expect. Pregnant women and women over 45 years old were under represented. The service had projects to try to engage these groups. Previously they had targeted veterans and younger people.
- The service had a good range of information displayed. Leaflets and posters were readily available in the waiting area. All information was in English. The service had used interpreters previously when needed.
- Staff were aware of the complaints procedure. Clients who complained received a written response to their complaints.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The service had robust governance structures in place to facilitate learning. Regular reporting and review of performance took place, both internally and with the local commissioner. The service manager put plans in place to address areas of improvement needed.
- Staff were happy in their roles and felt they worked well together to support one another. Staff felt supported by their line managers. Staff confirmed senior managers had visited the service in the previous couple of years.

Summary of this inspection

- The service manager managed staff leave, sickness and absence, and poor performance to ensure the service was safe to operate. Staff had opportunities for additional training and development.

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

- Staff confidence in more senior managers varied, not all staff would feel confident to raise a concern outside of the team for fear of reprisals. Some staff felt senior management imposed changes without discussion or consideration of the impact on their workload. There were concerns senior managers did not understand the large geographical area covered and the challenges this posed.
- The service although reporting incidents and safeguarding internally had not routinely notified the Care Quality Commission (CQC).
- Staff had minimal knowledge in relation to the Mental Capacity Act (MCA). Three staff had received training in the MCA. The provider had recently introduced MCA training but not all staff had yet completed it.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

- Not all staff had received training in the Mental Capacity Act. The company had introduced a new e-learning module staff were due to complete.
- The service had a policy on the Mental Capacity Act staff could refer to but the majority of staff we spoke with did not know this.
- The staff did record a client's consent to information sharing at the point of assessment. Staff told us if they were unsure regarding a clients' capacity they would seek advice. The service manager told us she would approach the team dual diagnosis lead. Other staff said they would seek advice from the service manager or contact social services. The service manager said if client capacity was an issue staff tended to be part of a process, either the local mental health team or social services led on this.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

- The service only saw clients at the Chesterfield base on the ground floor. Access to the building was via an intercom with a camera. Clients pressed the intercom and staff then allowed access to the building. The waiting room and two counselling rooms where fitted with alarms. We saw records that indicated staff checked the alarms monthly.
- The service administrator completed a daily visual health and safety check of the building. We checked the records and found on fifteen occasions staff had not recorded completing daily checks since February 2016. Staff checked fire alarms weekly, fire exits, and emergency lighting monthly. The service displayed fire exit signage and had fire safety doors throughout. Fire extinguishers were present. There was a fire systems and servicing certificate present dated 28/6/16. The last fire risk assessment dated 09/04/2015 had been carried out by an external company. Carbon monoxide detectors were present and records showed checked monthly. The service carried out an annual legionella test.
- The service did not have a clinic room. It did not have emergency equipment apart from a first aid kit. Within this service, this is acceptable. The service had information within their health and safety handbook, which detailed actions staff should take in a medical emergency. In this instance, it was to call emergency services. We saw when reviewing reported incidents that staff had called an ambulance when a client became unwell.
- Staff had completed infection control audits in North and South Derbyshire and Glossop offices during April 2016. We saw that the service had made changes following this.
- The Chesterfield building was old but visibly clean and tidy. Cleaning records were not present. Two external contractors attended weekly to clean the premises. The chairs in the waiting area were all fabric and showed signs of wear. As the chairs were fabric, it would have made them difficult to clean if needed.
- Stickers were present on most electrical equipment indicating checks in January 2016 to ensure it was safe to use. However, we did not see safety stickers on the microwave or fridge in the kitchen area.
- The service did not consider ligature risks as part of the environmental health and safety assessment. Ligatures are places to which patients intent on self-harm might tie something to strangle themselves.There were ligature risks present in unsupervised areas such as the waiting room. There had been no incidents of any client having ever ligatured in the building. As clients lived independently in the community if they wished to harm themselves, they had access to ways to do this.

Safe staffing

- The service had a registered manager and team leader. It had three full time qualified nurse prescribers and one part time nurse practitioner. There were five full time and one part time project workers and a full time administrator. The service had no current vacancies. The service did not use bank or agency staff.
- Staff sickness in the previous 12 months until July 2016 was 4.4%. This figure is comparable to NHS sickness figures. Staff turnover for the previous 12 months until July 2016 was 15%.

- The service manager used a team tracker to manage leave and sickness. We reviewed this as part of the inspection. Although staff worked generally in allocated areas, there was an expectation staff would provide cover in other areas if needed. The service manager worked to ensure there were always at least two qualified nurses within the service. There was only one occasion within the previous three months when there were not at least two qualified nurses on duty. The service manager did this to ensure if a nurse rang in sick then the service still had a nurse present. The service manager expected staff to ring into work by 8.30am if sick and give details of their appointments so staff could reallocate or cancel their work.
- The total caseload was 323 at the time of inspection. The average caseload per worker was 35. The service manager and team leader had reduced caseloads of between 15 and 20. Staff reported the service was under pressure and the workload was excessive. The service had seen a sharp rise in the number of referrals received. Recent changes to guidance meant nurses kept clients for longer to monitor the effects of prescribed medications. This meant there was an increased pressure on the service and staff members.
- The team leader and service manager reviewed caseloads on a monthly to six weekly basis. The service used a case management toolkit. The tool identified all service users on each worker's caseload, the frequency, and types of interventions, progress towards recovery and successful completions. Staff felt caseload supervision was helpful.
- The national target for clients to receive an assessment is 15 days. The service had identified 40% of clients waited over 15 days. At the time of inspection, the previous months' waiting times varied across the service ranging from nil working days to 28 working days.
- Staff completed basic mandatory training via an electronic training package. The service manager had identified further training and development for the team beyond mandatory training that staff were expected to complete. Following the inspection, we received an updated copy of the training matrix. This showed staff had completed in excess of 90% of mandatory training. The only area that was below 90% was in relation to the Mental Capacity Act as this was new training.
- Ten staff had completed and current disclosure and barring service (DBS) certificates in place. Two staff were in the process of renewing theirs. The service manager had requested one staff member re-apply, as they could not produce the certificate. DBS certificates check staff do not have any criminal convictions that would prevent them from working with vulnerable adults or children. The service kept appointment records for staff, which included an identification check, two references (one from most recent employer), and a DBS check. The service manager said that occasionally staff had started work with an existing DBS whilst awaiting the current check to arrive.

Assessing and managing risk to clients and staff

- We reviewed 15 client records across the three staff bases where they kept records. The service used the functional analysis of care environments (FACE) risk assessment. A nationally recognised assessment tool. It was also moving to a new electronic risk assessment and management plan. We found 13 records contained an up to date risk assessment. One record had a risk assessment present dated July 2014, and from a previous episode of treatment. One record did not have a risk assessment present.
- Clear unexpected exit from treatment plans were in place in three of the records we reviewed. They were not present in other records we reviewed although the service did have a local protocol for people who disengaged from the service, staff members were clear on actions they would take.
- The service contacted all clients referred to them by telephone. If clients had to wait for an assessment the service telephoned them periodically for 'check-ins' until they were seen.
- Staff received training in safeguarding adults and children. The service had reported 10 safeguarding incidents and made three safeguarding referrals between February and August 2016. Staff we spoke with knew what would constitute a safeguarding concern and explained to us how to report concerns. Twice yearly, the safeguarding lead from the local authority attended team meetings.
- We saw during our inspection staff adhered to the lone working processes in place. All staff carried mobile phones but due to the poor phone coverage in some

areas, the service had developed specific processes to manage this and developed a local procedure to further detail Addaction's lone working policy. The service had increased its use of community venues to minimise the need for home visits and to maximise clients' community engagement.

- Staff stored prescriptions in a locked safe and ensured a limited number of staff had access to them. There was also monitoring of the use of prescriptions. No medicines were stored on site
- The service did not exclude children from the Chesterfield service although it did not have a local protocol or policy for children being at the premises. Staff received training into safeguarding children. The manager informed us that clients were discouraged from bringing children with them to appointments. We saw two children accompanying clients during our inspection. Staff were not present in the client waiting area and it did not have CCTV to monitor it. Two clients told us they would have felt safer waiting if staff or CCTV were present.

Track record on safety

- There had been no serious incidents reported to CQC by the service in the previous 12 months.
- Local providers conducted alcohol related death reviews. Ten deaths had occurred in the community since February 2016 of people who had used the service. The service manager attended the joint meetings and bought learning back to her team. Following a recent death review, the service manager had identified staff did not always complete notes in a timely manner. Notes did not contain clear evidence of decision-making. The service manager had reminded staff regarding the importance of completing records as soon as possible and directed staff to include their reasoning for decisions taken and actions within client records.
- The provider had recently introduced a new risk and safeguarding assessment and management plan. Staff assessed all new referrals to the service using this. Staff had plans in place to re-assess existing clients with the new tool when they next formally reviewed the clients.

Reporting incidents and learning from when things go wrong

- The service had a process in place for reporting incidents. Since the 25 February 2016, the service had reported 25 incidents. It had reported safeguarding concerns (10), deaths of clients (10), and incidents relating to clients (4) and staffing issues (1). The service had only notified the Care Quality Commission (CQC) of one safeguarding concern and had not notified CQC of the deaths of clients. We would expect notification of all safeguarding concerns and client deaths.
- There were processes in place so learning within the organisation was widely disseminated. The critical incident review group reviewed incidents monthly. The service manager attended this. These meetings then fed into Addaction's national clinical and social governance group. Addaction provided a quarterly bulletin of incident reviews.
- Staff held team meetings monthly. We reviewed team meeting minutes for the previous six months. They had recorded learning from incidents and indicated changes the service had made. One example was following an adverse event staff had reworded the initial appointment letter to clarify expectations of clients attending. Staff were also informed of incidents, learning or changes via e-mail if the team meeting was a while away.
- Staff were aware of the duty of candour although the service had not had any incidents where this applied. The duty of candour is a regulatory duty that relates to openness and transparency. It requires providers to notify people who used services (or other relevant persons) of certain safety incidents and then provide reasonable support.
- Staff received both formal and informal debrief following serious incidents. Informal support was available via team members. The service manager or team leader would contact workers via phone if they were in a different staff base. Longer term, support was available via an employer assistance programme that offered up to 10 counselling sessions. Staff confirmed being offered debrief. One staff member felt debrief was not always offered as timely as it could have been.

Substance misuse services

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

Assessment of needs and planning of care (including assessment of physical and mental health needs and existence of referral pathways)

- We reviewed 15 client records across three staff bases, Chesterfield, Derby, and Glossop. The client records were paper based and in an electronic format. We found 12 client records were current and complete. They contained an assessment of need including drug and alcohol use, prescribed medications, treatment history, other services involved, physical health, mental health and client perception, client motivation to change and advice on harm reduction. Chesterfield records had the most detail. Three sets of records at Glossop were not fully completed. They did not contain an assessment of client motivation, an assessment of alcohol dependence or record of advice given regarding harm reduction. We did not see evidence of physical health assessment having taken place in one set of client records.
- Recovery plans were present in all 15 records we reviewed. However, the detail they contained varied across the service. We found examples of specific recovery based plans with clear goals at Chesterfield but we also found examples of recovery plans that lacked detail, review dates and stepped goals. One recovery plan at Glossop was from a previous treatment episode and dated 2014.
- Paper records were stored securely in locked cabinets. Individual staff members had log-ins to access electronic records that were password protected. The three staff bases meant staff had access to their notes when needed. The service was moving from paper based to electronic records for the completion of risk assessments. Of the records we reviewed 14 clients had risk assessments within written records and one was electronic. In one record we reviewed, the on-going record was in an electronic format, others were paper based. One worker was unable to locate a risk assessment for a client until the following day, as it had been misfiled. During this time of change, there is a risk information needed might not be easily located, which could pose a risk to clients.

Best practice in treatment and care

- The service followed guidance set out by NICE and Public Health England (PHE) and used this guidance to develop its assessment and recovery planning processes. The service used the severity of alcohol dependence questionnaire to assess client dependence on alcohol as directed by current NICE guidelines – alcohol-use disorders: diagnosis, assessment, and management of harmful drinking and alcohol dependence.
- We found within records that a community detox plan was compliant with local policy and NICE guidelines. We saw the plan detailed physical health monitoring that staff completed. Staff completed on-going assessments,monitoring the client during detox. Staff prescribed medication as directed by the policy.
- The staff received training in psychological interventions such as cognitive behavioural interventions, motivational interviewing and solution focussed interventions. The staff used these interventions to inform their practice. We saw staff employing goal setting skills and motivational techniques during the appointments we observed. We also saw staff discussed harm reduction with clients.
- Other local alcohol services provided group based therapies. Staff had an awareness of local activities and therapies available.
- Staff completed an assessment of physical and mental health needs. This was part of the initial assessment. Staff encouraged clients who had not had recent blood tests to complete this via their GPs. The records we reviewed did not contain detail regarding either the physical or mental health assessment. We saw staff as part of routine appointments reviewed clients' physical and mental health. However, we did not find staff updated client records with this information.
- Prior to providing prescriptions to clients staff considered potential risks. Staff assessed the safe storage of medication, this included consideration of children present in the household and support available within the home. Staff supplied limited prescriptions to clients with a history of overdose.
- The service used outcome measures, to monitor the effectiveness of interventions for clients. Staff used the

treatment outcome profile, a nationally recognised outcome measure. The tool can demonstrate individual client progress or services can use it to demonstrate outcomes they are achieving.

- The company had recently audited the service's recording keeping. This had highlighted improvements were needed within the clinical notes. We saw an action plan was developed. Several staff had undertaken peer review audits of notes to improve the quality of recording. The service audited prescription pads and records each month to check they were present and correct. The service had commenced an audit of the prescribing of a new drug (Nalmefene) but it was incomplete and no conclusions yet made.
- The service manager attended a six weekly Derbyshire clinical reference group that discussed trends and changes in practice. She shared information with the team at team meetings.

Skilled staff to deliver care

- The service had four qualified nurses. Three of the nurses were non-medical prescribers. The other nurse was completing the qualification. The service did not have a medical practitioner within the service. A local GP with a specialist interest in alcohol misuse provided 4-6 weekly clinical supervision for the nurse prescribers. The nurse prescribers felt they received sufficient support and supervision and said the GP was contactable between planned supervisions should they need extra advice. Six project workers were employed and an administrator to support the service.
- Staff received training in alcohol awareness, the key principles of working with people who misuse substances, blood born viruses, mutual aid partnerships, safeguarding, drug awareness, and dual diagnosis. Staff completed this training electronically it was provided by Addaction. The service expected project workers to complete within 12 months of employment an open college network course in substance misuse. This is a recognised and certificated course.
- Staff received an induction to the service. We saw a corporate induction form used. This included actions for both the new starter and service manager to complete. We met with a staff member who had recently joined the team in a new role having transferred from another office. The new staff member confirmed receiving a good induction to his new role and the team. The staff member was working on a reduced caseload until he was more established. The service employed new staff on a six-month probationary period.
- Staff received an annual appraisal, reviewed six monthly. We reviewed three appraisal records and found the formal review had taken place as planned. Additional objectives were added mid-term if staff had met previous objectives. Eligible staff (100%) had received an annual appraisal. New starters did not receive an appraisal until they had completed their probationary period.
- Staff received supervision four to six weekly. A supervision agreement was in place for staff identifying the aims and expectations of both the supervisee and supervisor. Prior to supervision staff completed a reflective practice sheet to prepare for supervision.
- Monthly team meetings took place. The service manager expected staff to attend team meetings. She reviewed team meeting attendance as part of supervision. The team meeting had a set agenda that included service updates, identified learning, and actions taken. The service manager had recently added a discussion of case studies to the team meeting agenda to facilitate learning and sharing. The team minutes we reviewed showed evidence of discussion and sharing taking place.
- The service manager and team leader identified staff performance issues through regular supervision. The service manager was formally working with one staff member to address poor performance.
- We reviewed three staff personnel files for the service. We found evidence of management regarding sickness absence and productivity with agreed actions and expected outcomes.

Multidisciplinary and inter-agency team work

- We saw within records regular communication with GPs took place regarding clients. Staff reported good links with GPs. Staff had established links with probation. Six monthly meetings took place. The service took clients subject to alcohol treatment requirements (ATR) orders who had committed offences and this was part of their sentence. Relationships with local mental health

services existed. They were strongest in Glossop as the worker was co-located with the community mental health team. The service reported good relationships with in–patient mental health services and local social services.

- The local commissioner for the service reported good open relationships existed. He had spoken with staff members, attended a team meeting, and observed staff client interactions. He was satisfied the service delivered was safe and effective despite the large geographical area and the limited staff numbers.
- Staff spoke knowledgably about recovery services and mutual aid groups that took place across the area. Staff had greater knowledge and understanding of the services available in the geographical areas they covered.

Good practice in applying the MCA (if people currently using the service have capacity, do staff know what to do if the situation changes?)

- Not all staff had received training in the Mental Capacity Act. The company had introduced a new e-learning module which staff were due to complete.
- The service had a policy on the Mental Capacity Act staff could refer to but the majority of staff we spoke with did not know this.
- The staff did record a client's consent to information sharing at the point of assessment. Staff told us if they were unsure regarding a clients' capacity they would seek advice. The service manager told us she would approach the team dual diagnosis lead. Other staff said they would seek advice from the service manager or contact social services. The service manager said if client capacity was an issue staff tended to be part of a process, either the local mental health team or social services led on this.

Equality and human rights

- The service worked with the Equality Act 2010. Within their central policies, all policies were quality impact assessed.
- The service had a project where it was working to try and assertively engage pregnant women.
- There were no restrictions on anyone accessing the service. All people over the age of 18 could access the service. Previously the service worked in a transitions project aimed specifically at young people from the ages of 18 – 25 years. This was a 3-year project and had ended in May 2016. The aim of the project was to raise awareness in younger adults and other providers. The intervention offered was not time limited.

Management of transition arrangements, referral, and discharge

- The 'hub' was a local initiative, which triaged all referrals and then sent them to the appropriate service. The hub carried out the initial assessment and screening of alcohol usage and signposted to the appropriate service. Addaction worked with clients who consumed more than 120 units of alcohol per week. If a client was drinking more than 100 units of alcohol but had other needs, for example pregnancy, then Addaction would provide the service. Clients reported a smooth transition through services although two clients reported a delay.
- Staff planned discharge with the client. Staff generally facilitated discharges to different local alcohol services, recovery services, and mutual aid partnerships or to residential placements. If there was, a wait until the service accepted the client referral Addaction remained involved. Staff continued to offer a point of contact and support for clients.
- The service had a process in place for clients requiring in-patient detoxification. A monthly funding panel of professionals and commissioners met. Recently clients had attended the panel alongside the Addaction workers to present their need for in-patient services. Staff felt this was positive and included clients in their recovery. The service used three different in-patient detox units, all were several miles away from the area.

Are substance misuse services caring?

Kindness, dignity, respect, and support

- Staff interactions we observed were warm, friendly, and relaxed. Staff were respectful, non-judgmental, and professional throughout. We observed staff giving information to clients in a way that was easy to understand. We saw staff provided advice and support that was appropriate to meet client needs.

Substance misuse services

- The nine clients we met with and the 16 comment cards we collected from clients were universally positive about the service. Clients confirmed staff treated them with respect and upheld their dignity. Clients felt listened to and staff supported and advised them in a timely manner. Clients felt the staff cared and that staff worked with them to identify treatment plans and goals.
- Seven clients told us they felt safe using the service. Two clients who accessed the service at the Chesterfield office felt the waiting room could feel safer if CCTV cameras were present. The waiting room did not have a staff presence.
- Clients had confidentiality and information sharing explained to them. We saw within the records we reviewed and interactions we witnessed whilst on home visits staff checked with clients what information they could share with others.

The involvement of clients in the care they receive

- Clients were active partners in the planning of their care. We witnessed staff reviewing progress and planning future goals with clients. Clients told us they were involved in making decisions and staff gave them enough information to consider their options. We saw no evidence that staff had offered clients a copy of their care plans in the records we reviewed. The nine clients we spoke with did not have copies of their care plans.
- Five clients told us staff offered advice and support to their families and carers. We witnessed during observations staff considered family members' needs. Staff were aware of local support groups available for families.
- The service provided the details of three different advocacy services. However, only two of the nine staff members were able to tell us about local advocacy services. The service manager told us clients usually already knew about advocacy services. Previous services had often referred clients for advocacy, if needed. The lack of staff knowledge regarding advocacy services could have negatively affected clients.
- Recovery champions, (previous clients), had been part of interview panels for staff appointments. To complete this role they had received training in giving feedback. Following the interviews, they gave feedback on the interview process. This demonstrated the service valued client involvement.
- At the time of the inspection, there were no volunteers within the service. Previous volunteers had left. The service had been expecting a volunteer but they had found full time employment.
- Nationally, Addaction completed an annual client survey. This service did not complete a local survey but did collect feedback from clients on an on-going basis. Local commissioner feedback for the previous 3 months (May – July 2016) showed 80% satisfaction with the service provided. During the month of July 2016, 100% of clients were satisfied with the service they received.

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

Access and discharge

- The service generally had waiting times for staff to assess clients. These varied across the area covered. The longest waits for assessments were for clients in the Chesterfield area.
- The service had identified 40% of clients waited over 15 days (the national target) for an initial assessment. At the time of inspection, the previous months waiting times varied across the service ranging from nil working days to 28 working days. Average waiting times ranged from seven working days to 20 days. The service broke their referrals down into nine local authority areas. High Peak area (Buxton) average wait was 17 working days and North East Derbyshire (Chesterfield) area wait was 20 working days. Both of these figures were outside of the national and locally agreed target of 10 working days. Staff felt the demand for services was greater than the service they could provide. Staff reported feeling under resourced due to an increase in referrals and changes to practice. Despite this, two parts of the service met the local targets, Derbyshire Dales with an average wait of seven working days and Derbyshire South did not have anyone waiting for an assessment. Once assessed as appropriate clients had a worker allocated.

- The service had employed a fixed term part time project worker to try to improve the waiting times. Additionally the service manager had increased the hours of two part time workers for a fixed period to try to reduce the waiting times. The service manager used her existing budget savings to fund these initiatives. The service manager had approached her contracts manager who had approved them. At the time of inspection, the service manager had changes planned to move staff into the areas with the greatest waiting times.
- Staff offered clients appointments in various community-based venues. Staff offered flexible appointment times, including evening appointments to meet individual client need.
- The service had a duty worker allocated daily who responded to any client telephone calls. The service aimed to answer calls promptly. Clients we spoke with confirmed staff provided them with the contact phone number. Clients said someone always got back to them if they rang for support. Other clients told us staff would just ring to check on them between scheduled appointments.
- The service had a clear inclusion criteria based on alcohol consumption. The criteria was not so rigid that it excluded people with co-existing complex issues who could benefit from the service but fell slightly below the threshold.
- The team proactively worked to engage clients who were under represented in their service. We saw an emphasis within one area aimed at engaging women over the age of 45 years, as this group were under represented in that area.
- The service had developed a local procedure to supplement Addaction's national policy on engagement. The procedure on client engagement, identified actions staff members should take if a client failed to meet their appointments. Staff we spoke with were familiar with actions they should take if a client failed to attend as outlined in the procedure.
- The service had changed its approach to try to reduce the number of clients who dropped out of the service. If a client missed two appointments then the service manager rang clients and offered an appointment to see how the service could better meet the client needs. We witnessed a telephone call to a client during our inspection. The service manager encouraged the client to attend an expectations meeting to work out jointly how the service could best meet their needs.
  The service manager stated this approach was proving successful at reducing the numbers of clients who left the service prematurely.
- Clients and staff told us appointments ran on time and staff rarely cancelled. If appointments were delayed or cancelled, staff and clients, confirmed staff contacted clients via telephone to inform them.

The facilities promote recovery, comfort, dignity, and confidentiality

- Only the service at Chesterfield saw clients on site. The service had a client waiting area, two counselling rooms, and a group room. The counselling rooms were close to the waiting area, next to each other. Each room had a viewing window. A client walking past one of these rooms would have been able to see who was in the room and vice versa. The counselling rooms were not adequately sound proofed and people could hear conversations from the rooms in the general waiting area, and from the room next door. The service had a radio playing in the waiting area but people within this area could still hear conversations, making client confidentiality difficult to maintain.

Meeting the needs of all clients

- The Chesterfield office where staff saw clients had difficult access for wheelchair users. A separate entrance was accessible but it involved negotiating two doors to get to the waiting area. There were further doors to get to the counselling rooms. The service did not have any toilet facilities on the ground floor. Toilet facilities were on the second floor and shared by clients and staff. Clients unable to negotiate stairs did not have access to a toilet. The service manager told us the referrals they received would identify clients with mobility issues. If needed the service would arrange to see them in a suitable venue.
- The waiting area had a good range of posters and leaflets displayed. We saw information on local and national support services and advice. We saw information about safeguarding concerns, how to complain and about the Care Quality Commission. All leaflets and posters were in English. Addaction did not provide leaflets in any language apart from English.

Between April and June 2016, the service had received six referrals for clients who were none white British. The staff had previously used a telephone interpreting service to communicate with clients who did not speak English. The service manager also gave an example of staff using community venues to support clients with hearing difficulties as hearing loops were available.

- The service had run a weekly group specifically for veterans. This group was well established and staff were now supporting the group to run without its input.

Listening to and learning from concerns and complaints

- The service had received 79 compliments, both written and verbal that staff had recorded up until August 2016, for the previous 12 months.
- In the same 12-months, the service had received two formal complaints that were not upheld. No complaints had been referred to the Parliamentary and Health Service Ombudsman. Staff had also informally recorded ten instances of negative feedback.
- The service had an information leaflet which contained details advising clients how to complain. Staff should have given the leaflet to clients at their initial appointment but three staff members did not assure us they always did this.
- Staff were aware of the complaints process and one staff member told us they had assisted a client to make a complaint. When a client complained, they received a written response.
- Staff used team meetings to discuss complaints and learning if identified.

Are substance misuse services well-led?

Vision and values

- The service manager knew the visions and values of the organisation.
- The team objectives were reflective of the wider organisations objectives. The service manager and staff were aware of the forthcoming changes and project closure plans were in place to maintain the service until March 2017. Morale had remained good.
- Staff knew who the senior managers of the organisation were and several staff confirmed they had visited the service at various times.

Good governance

- The staff received regular supervision and an annual appraisal. Staff completed training to enable them to carry out their roles effectively.
- The staff team met regularly. There were effective processes in place to enable the sharing of information with and from the wider organisation. The service reported incidents internally but did not routinely notify the Care Quality Commission. We saw the service had made changes in response to incidents.
- The team knowledge in relation to the Mental Capacity Act was limited. The company had introduced new training the team had yet to fully complete.
- The service manager reported to her organisation monthly on team targets, this included reviewing payment by results targets. The service manager reported three monthly to a local commissioner on contract indicators. Latest figures for July 2016 were exceeding targets in the majority of areas. Areas, which failed to meet the targets, were clients seen within 15 working days of referral 51%, (target 100%). Less than 30 % of clients not attending for initial appointments, service score 32%, and less than 20% of clients failing to attend for follow up appointments, service score 22%. The service had plans in place to try to improve these figures. The percentage of clients completing a service satisfaction survey was 80%, against a target of 100%.
- The team leader and service manager had sufficient authority to complete their roles. We saw several initiatives the service manager had introduced since being in post. We saw the service manager had taken measures to try to address issues with waiting lists within the service. She had sufficient administration support to enable her to complete her role.
- The service manager could submit items to the organisations risk register.

Leadership, morale, and staff engagement

- Sickness rates were 4.4 %. We saw when checking records the service manager monitored and proactively supported staff to return to work following periods of sickness. Staff were concerned about sickness levels as it impacted on their already busy workloads.
- There were no current bullying and harassment cases within the service, although there had been a case previously that had since been resolved.
- There were no whistleblowing cases in the previous 12 months.
- Staff felt confident to raise concerns with their direct management team. Staff confidence to raise issues within the wider organisation varied. Most staff said they would be confident to raise issues whilst three staff said they would be worried of reprisals if they did. There were concerns senior managers did not understand the large geographical area covered and the challenges this posed.
- The organisation had supported the service manager and team leader to complete leadership and management courses. Initially the team leader was a project worker but had progressed into her current role. The service manager used appraisals to set staff objectives. We saw staff leadership opportunities identified within this process. The manager supported staff to complete training to widen their knowledge. One staff member told us they had used 'shadowing' opportunities to increase her understanding of partner roles. Two staff members had funded training themselves but were given the time to complete the training.
- Staff enjoyed their jobs. Staff felt they worked within effective teams. Staff not based at Chesterfield felt their local teams had better relationships with each other than the team as a whole. Staff at bases other than Chesterfield often only met with the wider team or service manager for team meetings or supervision.
- Staff explained to clients if something went wrong. Staff gave examples to us to highlight actions they had taken. Staff told us they would explain and apologise if something went wrong.
- The service manager encouraged staff during team meetings to share ideas to improve the service. Three staff told us higher management imposed changes without trial or discussion. They gave examples of the recent change in risk assessments they felt had increased their workload as it was more time consuming.

Commitment to quality improvement and innovation

- The service had recently been involved in a project aimed at raising awareness with 18 – 25 year olds. The service had projects specific to particular areas of need and had jointly worked with other providers to achieve this.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must send notifications to CQC as set out in the registration of the service.
- The provider must ensure client assessments, risk assessments, risk management plans and recovery plans are current and fully completed.
- The provider must review the soundproofing of rooms and the viewing panels in doors to ensure the confidentiality of clients using the Chesterfield office.
- The provider must ensure it reviews disabled access to an appropriate toilet, as they are not meeting the needs of disabled people.
- The provider must ensure it has a local policy or protocol for children who may visit the service.

Action the provider SHOULD take to improve

- The provider should continue to work to reduce the waiting times for clients to be assessed.
- The provider should ensure they offer clients copies of their recovery plans and they record this within client records.
- The provider should ensure that they monitor clients and children visiting the service in the waiting area to help keep them safe.
- The provider should ensure all staff informs clients how to complain.
- The provider should ensure all staff are aware of local advocacy services.
- The provider should ensure all staff complete training in the Mental Capacity Act.
- The provider should ensure they have cleaning records that demonstrate cleaning has taken place.

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
Treatment of disease, disorder or injury	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services **The provider was not notifying the Care Quality Commission of incidents that required notification, including service user deaths.** **Regulations 16 (1)**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The provider was not notifying the Care Quality Commission of incidents that required notification, including safeguarding incidents.** **Regulations 18 (2)**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not ensure all client assessments, risk assessments; risk management plans and recovery plans were current and fully completed.** **Regulation 12 (2) (a)**

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The provider must review the soundproofing of rooms and the viewing panels in doors to ensure the confidentiality of clients using the Chesterfield office. Regulation 10 (2) (a) The provider must ensure that the premises used have accessible facilities for all people to use, including disabled people. The service must have due regard to the protected characteristics of the Equality Act 2010. Regulation 10 (2)(C)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must develop a local policy or procedure for children who visit the premises. Regulation 17 (2) (b)