Addaction Recovery Centre - Liverpool South ARC

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 areas of good practice:

- The service had enough staff to care for the current caseload of clients, with the average number of clients per each member of staff depending on individual complexities and comorbidities.Staff received timely supervision and appraisals and completion of all mandatory and additional training was up to date.
- The service had a GP medical lead and a non-medical prescriber. The service had volunteers and recovery champions, who were people who had experience of previously using substance misuse services.

Summary of findings

- Clients and staff both spoke highly of the positive atmosphere and sense of family across the service with a good rapport between staff and management.
- Clients who we spoke with were positive about their experiences of the service. They felt they were treated with dignity and respect by staff. They felt involved in their treatment planning and decisions while being provided with information about their care programme.
- Staff completed comprehensive assessments of clients, which included risk, which staff used to develop recovery plans. The holistic assessment clients' captured drug usage, physical, social and mental health care needs.
- The service had introduced a number of innovative approaches. It had also participated in a number of research projects with the aim of improving the health and social wellbeing of clients.
- There were established pathways for referring clients to the service from community detoxification services, GPs, the courts and the police. There were no waiting lists, and clients were usually seen within a few days of referral.
- Staff were able to identify and respond to risks and concerns including safeguarding and unexpected exits from treatment.
- Support and substitute prescribing was provided in accordance with national guidelines.
- Incidents, audits and complaints were reported, and reviewed centrally by the governance team at Addaction. Lessons learned were shared with staff using developmental techniques which focused on individual learning.
- The service monitored its performance and its impact on clients which it shared with commissioners and local partners.

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

- The service had no provision for monitoring safeguarding alerts they had raised.
- The service did not notify the CQC of the deaths of clients who were being prescribed under a shared care arrangement and where the regulated activity was not being provided by Addaction.

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Substance misuse services

Summary of this inspection

Background to Addaction Recovery Centre - Liverpool South ARC

Addaction Recovery Centre Liverpool South provides community substance misuse services for people in South Liverpool. The service is commissioned by the local authority, and all clients are funded through these arrangements with the city council.

Addaction Liverpool South is registered to provide the regulated activities:

- Treatment of disease, disorder or injury;
- Diagnostic and screening procedures.

At the time of inspection there was no registered manager in place. A registered manager is the legally responsible and accountable person for compliance with the requirements of the Health and Social Care Act 2008 and associated regulations. The provider had recently appointed a new service manager who had applied to become the registered manager for this service and Addaction Recovery Centre – Roscoe Street and was being supported in the interim by a registered manager from another Addaction service until registration processes have been concluded.

The service provides a drug intervention programme and accepts judicial referrals, working closely with people when they are released from prison. The service also provides and recovery services. The integrated service provides open access to people seeking help with a range of illicit substance use. They provide opiate substitute prescribing (such as methadone) by referral only. Staff are also linked with a number of GP surgeries, to provide treatment and support in partnership with the GPs, known as shared care.

Addaction Liverpool South is one of three Addaction recovery centres that provide services across the metropolitan city of Liverpool.

Addaction Liverpool South has not previously been inspected by CQC.

Addaction Liverpool South is owned and provided by a central charitable organisation, Addaction, who provide over 120 services across the United Kingdom.

Our inspection team

The team that inspected the service comprised CQC inspector Ishaq Mahmood (inspection lead) and two other CQC inspectors.

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?

Summary of this inspection

- 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:

- looked at the quality of the physical environment, and observed how staff interacted with clients
- spoke with two clients privately and a further five who were attended a group workshop.
- spoke with the clinical lead for the service
- spoke to one of the nurses from the Addaction health and wellbeing team covering the service
- spoke with the newly appointed service manager and a senior colleague supporting them from another Addaction service
- spoke with two other staff members
- looked at five care and treatment records
- reviewed two staff records
- carried out a detailed review of the medication procedures
- attended and observed a mutual aid partnership group meeting for clients
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

The clients we spoke with were positive about the service. They felt that they were treated with dignity and respect by the staff. They did not feel judged and said they were treated as equals. Clients knew what their care plan was, and were able to contact their recovery worker when they needed to, though not outside service hours.

Clients told us they felt safe, and had not had any problems with the service. Clients told us they knew how to make a complaint, but had not needed to do so.

Clients told us the service was always clean, and drug screening and one-to-one appointments were held in private rooms.

Clients said they were supported with their physical and mental health care needs. They told us that the service and their GP liaised with one another and with other professionals, such as community health teams where necessary.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The building was clean and safe and well maintained. Staff carried out routine environmental and cleanliness checks, and addressed any problems. Clinical waste was disposed of safely using single usage bins, which would be sealed once three quarters full.
- There were enough suitably skilled staff to provide care and support for the current client caseload. The service had a medical lead/GP and a non-medical prescriber. Vacancy rates, turnover and sickness absence were all low. Staff had completed their mandatory training.
- Staff knew how to report and escalate incidents. These were reviewed locally and corporately and any required action taken. Information about lessons learned was cascaded by the Addaction clinical advisory group using scenario based learning, with teams having to submit answers to the group and appropriate recommended actions discussed at follow up meetings.
- Staff were well qualified and experienced to perform their roles well.
- Clients had a risk assessment and their recovery plan incorporated these risks.
- Staff knew how to identify abuse and respond to safeguarding concerns.
- Medication was not provided at the service. Clients were assessed and prescriptions were provided, which clients collected from local pharmacies. There were processes for dealing with pharmacy issues, such as lost prescriptions, diversion or missed collections.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients were asked for their consent to share information with others.
- Staff received regular supervision and had had an appraisal of their work performance within the last year.

Summary of this inspection

- Staff had received training to carry out their role and had additional training available to further develop and enhance their knowledge and expertise.
- Clients received a comprehensive holistic assessment of their needs, from which a recovery plan was developed. This addressed each client's drug usage, social, physical and mental healthcare needs.
- Support and substitute prescribing was provided in accordance with national guidelines.
- The service had introduced and participated in a number of initiatives to improve the physical wellbeing and health outcomes of its clients.
- The service had established effective working relationships with other organisations and groups involved in the care and treatment of its clients. This included local GP practices, the local commissioning group, pharmacies, the police and the criminal justice system. The service also had good networking with other recovery communities and local organisations.
- The service offered a range of evidenced based psychosocial interventions for clients. All staff had received training in psychosocial interventions and the service has access to a counsellor.
- The service used a wide range of outcome measures to measure the effectiveness of treatment. Results were used proactively to identify and drive areas for improvement within the service.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The clients we spoke with were positive about the service.They told us that they felt staff were genuinely concerned about their well-being and were respectful of their individual needs and preferences.
- The provider valued client engagement in the running and development of the service. There were various forums in which the provider encouraged clients to become involved. Examples included discussing plans for the services new location and staff recruitment.
- Staff involved clients in the compilation of their care plans and regularly reviewed them collaboratively thereafter.
- Clients felt that they were treated with dignity and respect by staff.

Summary of this inspection

- Clients were provided with information about the service. The initial assessment included information about what the service provided. Individual expectations of both clients and staff were clarified.
- The service utilised community recovery champions, who were people who had previously used substance misuses services and were now helping others.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

Information leaflets were available on a range of subjects. This included information about specific drugs, health conditions, dealing with symptoms such as cravings, and accessing support for other issues such as welfare advice or domestic violence. Staff were also able to use online tools to provide information in different languages

- Clients had access to a wide range of activities, resources and sessions without prolonged waiting. The service did not operate a waiting list and clients were usually seen within a week of referral.
- Referral pathways were in place for accepting referrals from various channels including community services, GPs and the courts/probationary services.
- The centre was open five days and one evening a week, offering a range of diversional and therapeutic sessions.Clients also had access to other services provided by the parent organisation, Addaction, at other sites across the city.
- Information for clients was available in a variety of formats including audio, graphic illustrations and paper text. Printed information on alcoholism was also available in Russian and Latvian. Other information leaflets were also available in other languages using the service's websites audio and translation facility, browse aloud. The service also had access to a translation service if needed.
- The service had a current complaints policy and procedure, which clients were aware of. Posters were displayed outlining how clients could complain.

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

- The current location was not very accessible, located in a commercial/business area, away from public transport. The service had recognised the problems of the current premises and had made plans to move to another location.

Summary of this inspection

- The service shared its premises with another organisation. It was mainly based on the upper floor of the premises but there was limited signage and no stair lift available for any individual who may experience mobility difficulties. This was mitigated by the fact clients were always accompanied to and from the main entrance and any clients with mobility difficulties could be seen in the downstairs clinic room, though this was not an ideal environment for consultations.

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:

- The service did not report deaths of four people using the service to CQC.
- The service did not have processes in place to monitor and audit notifications and thus there was confusion as to whether deaths and other incidents had been reported.
- The service had no provision for monitoring safeguarding alerts they had raised...

However, we found the following areas of good practice:

- Addaction provided staff with a range of developmental opportunities to improve their professional skills and expertise.
- There was strong leadership and desire to support staff develop and enhance their expertise. Senior staff members either had completed or were due to commence management and leadership training provided by Addaction.
- There were effective systems and processes in place for monitoring staff training and service outcomes. This included comprehensive audit tools and schedules. Results were used to drive service improvement.
- The service demonstrated a commitment to research and innovation to improve the treatment and outcomes of those using its services. This was done in partnership with local hospitals, national charities and universities.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

The service had a Mental Capacity Act policy, which was part of a set of safeguarding policies. All staff had completed Mental Capacity Act training and could refer to a process flowchart to follow if in doubt. In accordance to the first principle of the Act, all clients were presumed to have capacity to make decisions about their treatment unless there was evidence to suggest otherwise. Staff therefore did not carry out a formal capacity assessment of all clients. However the assumption was not recorded in the care records we reviewed nor was there a central record of instances when a capacity assessment was required.

If staff had concerns about a client's ability to make decisions they were required to delay the decision making process or refer them to the doctor to assess their health and their capacity to consent. This included clients who appeared intoxicated.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Substance misuse services	N/A	N/A	N/A	N/A	N/A	N/A

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

The building generally appeared clean but dated. The service was spread over two floors, though the service mainly used the upper floor, with another organisation using most the ground floor. All rooms used by clients were fitted with alarms, which staff used to alert other staff members in event of an emergency. If an alarm was activated all available staff were expected to respond and check where the alarm had been activated. Staff confirmed alarms were rarely sounded. The clients we spoke to felt that the service was always clean and had their privacy respected by having one-to-one appointments held in private rooms.

The clinic room was used for drug testing purposes and was equipped with the necessary items needed to do this safely; adhering to infection control procedures and to ensure safe disposal of any sharps. The sink unit was foot operated and a bin was situated close by and there was also an accessible toilet present. The service had suspended a needle exchange programme previously offered from the site, following a recent audit, which highlighted concerns regarding how well the current premises were equipped for this purpose. The service intended to restart needle exchange once they had moved into new premises. In the interim the staff gave out details of other local syringe exchange programmes if needed.

The building owners were responsible for cleaning the building and all rooms within it. Individual rooms were cleaned on the day of their use, and all other areas were cleaned weekly. There was a list of control of substances hazardous to health (COSHH) and guidance regarding appropriate storage of such products, for example cleaning products.

The provider had a health and safety portfolio, which included policies, audits and checklists related to health and safety. The service last carried out a health and safety assessment in July 2017. This asked questions related to a number of areas, which included, fire, utilities, waste disposal, panic alarm checking, disability access and infection control.

The fire safety procedure contained information for staff about the management and safe evacuation of the building in the event of a fire. Five staff were trained fire wardens and were recognisable by use of high visibility vests to be worn in the vent of the fire alarm sounding. There were fire exit signs and information around the building. Fire risk assessments formed part of the health and safety assessment. Addaction's policy required for regular fire evacuation drills, which once done were documented in the health and safety portfolio. Staff had completed health and safety training that encompassed fire training. There were fire extinguishers in the building and they had last been serviced in August 2017.

There were first aid boxes in the clinic room and office, both of which were checked regularly and in date. The service had named staff that had completed first aid at work training within last three years. The consultation rooms were well kept and of average size.

Safe staffing

All staff were required to undergo a Disclosure and Barring Service check along with completion of references prior to commencing work with the service. These were co-ordinated by the Addaction central business hub and up to date for all staff and volunteers. The service had an induction process for all staff and volunteers joining the service, which included the provision of appropriate training support and supervision.

The service recently appointed a service manager who had applied to the commission to become the registered

manager for this and another service. At time of inspection 2.5 whole time equivalent team leaders worked at the service along with six recovery/key workers, one recovery champion, three volunteers and two administrators. The service also had one registered adult nurse who was present half a day a week. However as part of the Addaction health and wellbeing team serving all the local services run by Addaction, the nurse was available over the phone when required. A prescribing doctor worked at the service one day a week, and a non-medical prescriber worked at the service when the prescribing clinician was not available.

The service had no vacancies at the time of our inspection though there were pending discussions about recruiting into the role of a recently promoted member of staff. The service reported 17 days of staff sickness over the last 12 months, with no prolonged episodes of absence reported over the same period.

There were 215 adults on the services current case load, with the caseload per recovery worker ranging from 15 to 86. Staff supporting clients with more complex needs, requiring intensive support, had smaller caseloads.

All new cases were screened by team leaders who had oversight of all caseloads and decided on case allocation. At team leader discretion cases could be moved to help accommodate staff and creating manageable workloads, however this would only be done in consultation with individual clients and would entail a formal handover process.

The provider did have a volunteer programme, which was coordinated from another site. All volunteers received appropriate training to enable them to carry out their role.

All eligible staff had completed mandatory training in safeguarding children, safeguarding vulnerable adults, safeguarding information, health and safety including first aid, infection control and prevention, equality and diversity, substance misuse and mental capacity. There was a training dashboard for all staff, and their managers, which clearly showed if training had been completed.

Assessing and managing risk to clients and staff

We reviewed five treatment and care records and spoke with two clients. All client records had risk assessments including an initial risk screening which was completed on referral to the service. Risk screening at initial assessment captured details of previous drug use. It also documented risks associated with an individual's mental and physical health, social circumstances and substance misuse use history. It included potential risk areas such as any history of overdoses, known health problems, blood borne viruses, injecting sites, and criminal justice information. Staff used this information to develop action plans and put measures in place to ensure clients and staff were kept safe when visiting the service. Risk assessments were comprehensive and covered risk to self, risk to others, personal safety, neglect, childcare, mental health, physical health and relationships. Recovery workers reviewed and updated risk assessments at 12 week intervals, however it was evident that Recovery workers routinely did this more frequently following individual contact with the clients and when a change in risk had been identified. The frequency of risk assessments was monitored by team leaders and discussed during staff supervision. Recovery plans incorporated and reflected the client's risks.

Prescribing was done in accordance to national guidance and varied depending on clinical need and requirements. Urine and saliva screening could be routinely carried out to check for illicit use. The risks posed by blood borne viruses were discussed with clients and links with community and hospital Hepatitis teams utilised if required.

The service did not routinely store or dispense medication other than Naloxone, which a nurse took responsibility for monitoring and who would ensure the inventory was correct and all were within date. Prescriptions were issued by the prescribers for clients to take to their preferred pharmacy. Staff assisted clients with information on which pharmacies were most convenient and open seven days a week in their area if this was needed. The service would liaise with pharmacies to ensure medications were being collected. There was a documented auditable process for the management of prescriptions, and all prescription pads were securely stored in a locked unit in a secure office, which was within the area only accessible by staff. The service followed Addaction's corporate medicine management policies. The non-medical prescriber at the service was a nurse who was overseen by the clinical lead for the service in accordance to Addaction's non-medical prescribing policy.

Staff we spoke with were able to identify abuse and recognise signs of potential safeguarding concerns. The service had local and corporate safeguarding policies, and

a process flowchart about safeguarding for staff to follow. There was a safeguarding lead within the service and a clear process for recording, reporting and escalating concerns.

We were told that safeguarding referrals were rarely made as clients were already known to other agencies including social services, which were often already support them. The service did not have a system for monitoring safeguarding alerts. The service had established links with the local authority social services. Staff said they knew how to escalate safeguarding concerns to their manager or medical lead when required.

In ensuring clients also had a safe environment at home, safe storage boxes, were given to clients with children, to safely store medication. This was facilitated through arrangements made with the service commissioner.

Staff did not routinely see clients in their own homes but the service did have a lone working policy and processes to safeguard staff for when this was required. This included utilising a combination of panic alarms and a look out call monitoring system.

Track record on safety

Data provided by the service prior to our inspection for a year to July 2017, showed there had been no reported serious incident or death of a client that required investigation. However, during our inspection we found that the service had notes identifying four client deaths over the same period, which the service had failed to notify us about as required by their registration.

The service had a system in place to ensure that improvements in safety were made following the death of clients, by participating in the Liverpool wide death review panel and sharing learning. This was hosted by the commissioners in Liverpool and had multi agency participation. All services were required to provide the panel with background and a summary of the care of any deceased clients with oversight from Addaction's central clinical advisory group.

Reporting incidents and learning from when things go wrong

Staff awareness of what constituted an incident was not always clear with some telling us only more serious matters needed to be reported. Staff did know how to report incidents and whose responsibility this was. The service used an online reporting system, which anonymised information to protect clients and allowed for triaging to the appropriate manager and designated lead for review. Any staff could report an incident. Incidents were reviewed by managers who had five days to respond and who followed up the reports and any actions. Reports and action details would then be sent to the Addaction central incident team for review. The most common types of incidents involved client prescriptions. These were reviewed, within appropriate timescales for investigation and action monitored.

Incidents were also reviewed and analysed centrally by the relevant Addaction review group. They collected information about incidents, from across all Addaction's services nationally, and looked for trends and lessons learned. They would share these through emails sent to all staff, e-bulletins or scenario based learning during team meetings.

Staff could access a face to face or telephone-counselling service following serious or traumatic incidents.

Duty of candour

Staff were aware of their responsibilities under duty of candour, to be open and transparent with clients when things go wrong with their care and treatment, giving them reasonable support, truthful information and a written apology where appropriate. There were no recorded incidents, which met the threshold for a formal apology stipulated by duty of candour.

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

Assessment of needs and planning of care

We reviewed five care and treatment records, which we found to contain comprehensive assessment of individual needs. The service used its own "Addaction Liverpool Universal Assessment" pack. This was an extensive assessment of the client's previous history and individual needs, including drug and alcohol use, risk, social care, mental and physical health.

Care records consisted of a detailed assessment of drug and alcohol use. This included the substance(s) which were being used, how much and by which route. Clients were

asked about their previous access to treatment, assessment and screening for blood borne viruses such as hepatitis and HIV. They were provided with harm reduction advice, and assessed for their motivation to change.

The physical assessment reviewed details of any known allergies, other physical health problems and other medications which were being taken. Clients were advised and supported with their physical healthcare and signposted accordingly. If any physical healthcare concerns were present clients were referred to the nurses in the health and wellbeing team. Nurses were seen to review ulcers, to change dressings and help managing long term conditions. Where nurses in the health and well-being team where unable to provide treatment, they would advise clients to visit their GP while supporting them to make an appointment and offering to accompany them where necessary.

We spoke to two clients who spoke positively about their experiences and felt involved in their care planning. They felt that they were supported with their physical and mental health care needs. They said that the service and their GP liaised with one another and with other professionals such as community health teams where necessary.

Staff asked clients about their goals for treatment, any changes they had already made, and their key strengths. The recovery plan was then developed in collaboration with the client by proposing treatment options for further treatment and the client choosing the options best for them with support from the recovery worker. All care records we reviewed had a recovery plan which was reviewed during one-to-one sessions with their recovery worker. Recovery plans were signed. The recovery plans were individualised.

A contract regarding their care, their rights to confidentiality and a complaints agreement were signed as part of the assessment and planning process. This included the expectations of the client and the service.

The provider had carried out an audit on all case files, which identified that improvements were required to standardise how these were written with the aim to use only electronic records in the future.

Best practice in treatment and care

The service adhered to national guidance from the National Institute of Clinical Excellence, Public Health England and the Department of Health. These were incorporated into Addaction's corporate policies which the staff were required to follow.

In accordance to current best practice, clients had a recovery plan and were supported with their health and social needs. Individual client consultations comprised of an assessment of treatment needs and goals, review of physical, mental health and social care needs.

Staff had all had training to develop the skills required to carry out a recovery focused role. This included using psychosocial interventions and one-to-one reviews that looked at longer term recovery of clients. Staff supported clients with practical issues to assist individuals with their activities of daily living including benefits, employment and housing needs. These needs were addressed in individual recovery worker sessions. Recovery workers would signpost or refer clients to other services and organisations for additional advice and support as and when necessary.

The service used peer mentors to support others with their recovery. Peer mentors, were stable in their own treatment before being recruited, were offered training and support to work in the service.

The provider had a team, the health and wellbeing team, dedicated to meet the physical health and wellbeing of its client base which worked across the Addaction services in Liverpool. The service was involved in two research projects, which aimed to reduce health inequalities. These focused on improving diagnosis and access to treatment for clients with chronic obstructive pulmonary disease and hepatitis C respectively.

The data lead for Addaction collated information from all the recovery centres in the city and sent it to the National Drug Treatment Monitoring System. All drug treatment agencies must provide a basic level of information to Public Health England each month, through the National Drug Treatment Monitoring System. The services submitted 'Treatment Outcomes Profile Plus' data, often referred to as 'TOPs'. This was a summary of standardised information about clients who used substance misuse services. The information measured the progress of individuals, and built a national benchmark of how services were impacting on

the lives of people within drug and alcohol services. We did not identify any concerns as to how Addaction Liverpool South had been collecting and submitting this information when required.

Skilled staff to deliver care

All staff had completed an annual work performance appraisal. This was reviewed during regular supervision meetings. The staff appraisal template used by the service referenced the core values and objectives of the provider organisations. Staff each had a training needs assessment matrix, which showed the training staff had completed and any mandatory or further training they required or which was out of date. The sample reviewed showed that plans developed at appraisal were implemented through the year.

All staff received regular supervision which was aimed to occur every six weeks and this was evidenced in the staff records we reviewed. During supervision, staff would discuss their current workload including the number of referrals and discharges, detailed caseload monitoring including number of appointments offered, attended and numbers which did not attend. Specific client issues were discussed, in addition to recording and updating of records.

Staff were able to address any workload or team concerns and any sickness and absence was discussed when necessary.

Staff had a range of different skills, and had undertaken additional training. This included specific substance misuse training such as National Open College Network qualifications, motivational interviewing and cognitive behavioural approaches. Level 2 counselling training was also available for recovery workers. Some staff had completed training in psychological-based techniques such as clinical behavioural analysis. The Medical director ensured revalidation certificates for prescribers were up to date and that medical staff were suitably qualified to prescribe in a substance misuse service. The minimum qualification requirement was the RCGP substance misuse accreditation, level 1 certification, though the doctor for the service had also completed the level 2 module for substance misuse. The medical director also oversaw all clinical supervision for all prescribers.

Multidisciplinary and inter-agency team work

The service's multi-disciplinary team comprised a service manager, team leaders, recovery workers, a prescribing clinician, a counsellor, a registered general nurse, a recovery mentor/champion, administrators and volunteers.

Clients referred to the service for treatment were managed either by the service or via a shared care arrangement between the service and the registered GP practice for the client. Individual treatment needs were assessed by the service during a consultation from a doctor or non-medical prescriber. A collaborative working approach existed between clinical and non-clinical staff, working closely with Recovery workers who developed a rapport and understanding with clients, often accompanying them to consultations.

The service held regular meetings with staff, including the multi-disciplinary team and daily flash meetings. The multi-disciplinary team meetings occurred every two weeks and were well attended by staff within the service. The meetings offered an opportunity to discuss new developments within the service locally and at provider level. Staff we spoke with felt able to raise concerns and appropriately challenge others to help improve service performance. Team leaders also facilitated smaller multi-disciplinary team meetings to discuss staff caseloads and share ideas regarding complex cases. The service had built strong working relationships with other organisations involved in the care of their clients. This included local dispensing pharmacies, local GP practices, criminal justice and probation services. The service also provided training to other services including GP practices, trainee GPs and the Department of Work and Pensions, to raise awareness of substance misuse difficulties and improve knowledge relating to treatments available.

Staff had dedicated links with GP practices to provide shared care for its clients, which incorporated support for the individual and prescribing arrangements.

The service linked in with community mental health teams and other community services as necessary.

The service had been part of a Liver clinic pilot for identifying and working with clients with Hepatitis C, which was run by Imperial College with the support of the local acute NHS hospital. The service had also taken part in a project offering accessible drop in sessions and support to those mixing substance misuse with sex.

Substance misuse services

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

The service had a Mental Capacity Act policy, which was part of a set of safeguarding policies. All staff had completed Mental Capacity Act training.

The service had produced a mental capacity flow chart that was visible within staff areas of the building. The flow chart served as a visual prompt to remind staff of the process for assessing a client's mental capacity should this be required.

Staff we spoke with had some understanding of capacity and consent. They were aware of the first principle of the Mental Capacity Act and said they normally presumed individuals had capacity to make decisions regarding treatment

unless signs indicated otherwise. Staff did not routinely carry out a formal capacity assessment, but were aware that intoxication may impair a person's ability to make decisions or mask other health conditions. If staff had concerns about a client's ability to consent, they would refer them to the doctor for review, and/or delay their prescription and ask them to return the following day so they could be reassessed.

During the initial assessment, clients were asked for their permission to share information with others and for details of family and friends that the service could contact if the client was unavailable.

Equality and human rights

The service had an equality and diversity policy. Equality training was mandatory and all staff had completed this within the last year. Clients had a care plan based on their individual preferences and needs. The service did attempt to cater for a diverse population by making information leaflets available in other languages and having access to a translation services when needed.

Management of transition arrangements, referral and discharge

There were clear pathways for shared care with GPs, and for accepting referrals from the community detoxification services, the courts and police. Shared care for prescribing was supported by link staff from the service holding routine clinics at GP surgeries. Clinical letters were sent to GPs following prescription reviews. The service had a transition pathway to facilitate any clients entering the service from adolescent services. The service was accessible by referral by other agencies though previous clients could self-refer themselves back to the service.

Are substance misuse services caring?

Kindness, dignity, respect and support

We attended and observed one support group, the mutual aid programme, during which we witnessed positive interactions and saw effective examples of mutual aid and support.

Clients we spoke with knew what their treatment plan was and felt they were offered advice and support. They were positive about the service they received. They were treated with dignity and respect by the staff, and felt they were not judged. They were able to contact their recovery worker when they needed to, felt that staff were supportive, and spent time with them. The interactions we observed between staff and client were respectful.

Clients told us they felt safe, and had not had any problems with the service.

Individuals' right to confidentiality was considered as individual care records included a signed confidentiality agreement that was completed at the beginning of treatment. Information regarding treatment was only shared with other organisations, agencies or professionals involved in the care of the client and other significant people including families and friends where a client had identified and consented to this.

The involvement of clients in the care they receive

The care records we reviewed illustrated that the service did involve clients in their care planning and review, with both direct quotes and goals stated. As part of the initial assessment, clients were asked about their history and their motivation to change, before being provided with information about the service including individual expectations. The service encouraged client participation and involvement in activities to shape and develop the service. This included participation in staff recruitment panels and forums for planning the new building.

There was also a clear strategy in place to focus on reducing harm and focusing on recovery care with clients

encouraged to reduce or stop their substance misuse, but not told they must do so. The plan of care was reviewed at each session. At each session clients signed their agreement with their plans.

There was a clear process for developing clients beyond their time as recipients of care, from opportunities to become volunteers, peer mentors, recovery champions.

Recovery champions, volunteer peer mentors members who were people who had used substance misuse services, were part of the team. They may or may not be abstinent, but had to be stable in treatment. They completed a training programme, and had ongoing support and supervision whilst working in the service. Their role varied depending on the individual from greeting and meeting other clients to participating in meetings. Clients could give feedback regarding their experience of the service in a number of ways including using the comments and suggestions box located in reception, a monthly client feedback forum and an exit from treatment feedback form when they were discharged from the service.

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

Access and discharge

The service was available from 9am to 5pm from Monday to Friday with one evening clinic each week. The evening clinic tended to be used by those clients who were subject to a shared care agreement whereby their care and treatment was shared between them and other care providers, and who needed flexibility because of childcare or work commitments. Clients we spoke to told us they would like the service to have provision out of hours. Clients could attend any of the three Liverpool recovery centres.

The service had a caseload of 215 clients, with an average of 73 clients seen per week. Over the previous 12 month period the service had discharged 155 clients. The clients we spoke with said they had not had a session cancelled or rescheduled. Clients could be referred to the service from a number of routes including direct GP referrals. When a referral was accepted, a date was agreed to meet the client, which could vary from the following working day to within 5 working days. The service did not operate a waiting list.

There were agreed processes for accepting clients from GP practices, and it was clear who was responsible for care and this could include jointly managed care assessments between the service and GP.

Clients had a review session with their key worker every few weeks. There was a daily provision of activities, courses and workshops which clients could attend at any of the three recovery centres. These included music groups, women's groups, communication techniques programme and courses on developing communication techniques. Any client who did not attend would be followed up by phone call or letter on the same day. The service did not follow up discharged clients.

The service took active steps to engage with vulnerable people and those who were reluctant to engage with the service by having a dedicated outreach provision in various community locations. This included having a visible presence in children's centres and midwifery clinics whilst working with other services to provide street drop in's.

The facilities promote recovery, comfort, dignity and confidentiality

There were active plans to move to a larger and more suitable building. The service confirmed that the new building would be more accessible to the population the service serves because it would be centrally located with good transport links.

The clinic room was situated on the ground floor and had no seating, which normally would not be an issue unless it was needed for consultations by those with a physical impairment. Consultation rooms were situated on the first floor along with the staff offices. Consultation rooms were private and had information leaflets available, and a limited number of posters on display. There was a waiting area for clients which had a notice board and a suggestion box for clients.

The service provided a five day activity programme which was delivered in conjunction with other Addaction services in the city, with clients able to attend any of the three sites. Groups included mindfulness, music and creative writing, and support and training to help clients gain employment. There were specific groups around health issues such as hepatitis C, and support groups for clients who used specific drugs. The service made available a monthly timetable of groups and activities to all clients.

Substance misuse services

Meeting the needs of all clients

The service could provide information and leaflets in languages other than English as needed including eastern European languages and Russian. Staff accessed support from telephone interpreters if required, or booked interpreters to support clients in person if they preferred.

Clients with restricted mobility could not access consultation rooms on the first floor as there was no lift or stair-lift. However, rooms on the ground floor owned by another service were bookable.

The service had also taken part in a project offering accessible drop in sessions and support to those mixing substance misuse with sex.

Listening to and learning from concerns and complaints

The service had not received any complaints over the 12 months up to May 2017, and had received 25 compliments over the same period. The complaints policy was on display around the building. Clients told us they knew how to make a complaint if they wanted to. Staff were aware of the complaints policy and how to respond when complaints were made.

Clients were also able to raise concerns with staff informally either during their consultations or during group sessions which would then be discussed at team meetings.

Are substance misuse services well-led?

Vision and values

The service manager often referred to the values of the organisation . These values were, to be:

- Compassionate,
- Professional
- Determined

The service objective was to be effective and productive. This underpinned the organisations aim to empower success and make positive change as clients regained control of their lives. The service aims and objectives were reinforced by a comprehensive five year strategic plan

Staff were aware of the vision and values of the organisation, and felt that their behaviour and actions reflected them. Addaction's values and guiding principles were on display in the building and on the services website. We were also told that senior managers from Addaction would occasionally visit the service including the contracts manager.

Good governance

The service did not notify the CQC of the deaths of clients who were being prescribed under a shared care arrangement and where the regulated activity was not being provided by Addaction. This was a breach of regulation. The service did not have processes in place to monitor and audit notifications and thus there was confusion as to whether deaths and other incidents had been reported. The service had no provision for monitoring safeguarding alerts they may raise as a service.

Systems were effective in ensuring that all required staff had completed the service's mandatory training programme had received an appraisal of their work performance within the last 12 months. Staff participated in clinical supervision with their team leader or line manager every four to six weeks. The service manager and team leaders monitored staff completion of supervision using Addaction's electronic dashboard.

Addaction had a corporate risk register but the interim manager had identified other local risks and concerns which she had the new service manager had identified and had already started to address. At the time of our inspection the main issues of concern included:

- The building layout was not ideal
- The clinical room was deemed not appropriate for needle exchanges,
- Risk planning checking needed to be more robust
- The need for managing admissions and discharges in real time.

The service met with commissioners on a monthly basis to update them on service provision and key benchmarks and to review new admissions and discharges regularly.

Addaction had integrated clinical governance, which was implemented by senior leadership team and the clinical and social governance group, and overseen by the board of trustees. The Directorate of Clinical Governance provided clinical and medical leadership to the organisation, which was led by the medical director. The data administrator

collated all the relevant information each month which the service used to produce a quartile review, giving a comparison of how the service was performing in comparison to other Addaction services.

The central Addaction critical incident review group reviewed and analysed incidents and complaints. Serious and critical incidents were also reviewed by regional hubs. The regional hubs and the critical incident group reported to the national clinical social governance group.

There was a schedule of audits, carried out by a corporate audit team. This included a regular case note audit. The most recent case note audit had found the records were not standardised in their level of detail and formatting. The service was developing an action plan to address this.

Policies were stored on the service's shared network drive and the intranet, which was accessible to all staff. There was a paper folder of key policies which included safeguarding, confidentiality, risk assessment, dealing with drug use on the premises, record management, supervision, incidents, drug testing, whistleblowing and lone working.

Leadership, morale and staff engagement

Since April 2016, there had been reconfiguration within the three Addaction services in Liverpool, which included changes to locations, and the activity at those locations. Staff had changed from working within a specific part of the care pathway, to working across multiple pathways. They now provided an integrated service focusing on recovery, criminal justice clients, and alcohol treatment requirements. There had been a recent change in management. Staff told us though there been some uncertainty at first, it was now a much better place to work and they found management to be supportive.

Staff knew the whistleblowing policy and felt they could speak out about the service. They told us they had plentiful opportunities to do so during staff meetings, daily flash meetings and during their own individual meetings and supervision with the managers and team leaders. They gave feedback about the service as part of their supervision.

Morale at the service was positive and staff told us that they felt valued and supported to develop their professional skills and knowledge.

Team leaders and managers had an opportunity to complete a leadership and management course, which the newly appointment service manager was scheduled to do later in the year.

It was clear that there was a process for progressing both clients and staff within the staff, with training and support available to both to gain the appropriate skills and qualifications.

Commitment to quality improvement and innovation

The service demonstrated a commitment to quality improvement and innovation to help remove the barriers clients faced when attempting to access treatment. The service participated in research and other initiatives that aimed to reduce health inequalities. One initiative was the Hepatitis C Assessment to treatment, HepCATT, project. This was collaboration between three NHS hospitals in Liverpool and Addaction, and focused on the identification and treatment of hepatitis C. A nurse from the liver unit at an acute hospital saw clients at Addaction for a few days each week. Additionally recovery champions were given training to become HEPCATT buddies to support others to access treatment by accompanying them and sharing their own stories. This had increased the uptake of treatment by clients following testing.

Another project identified those at greater risk of developing chronic obstructive pulmonary disease and offered them spirometry testing in Liverpool's shared care practices. People who have inhaled opioid based illicit substances are at an increased risk of developing physical health problems of the respiratory system including chronic obstructive pulmonary disease, asthma, pulmonary fibrosis and cystic fibrosis. The research was aimed to identify chronic obstructive pulmonary disease at an earlier stage, so that clients could be linked into their GP for monitoring and treatment.

In another initiative the service had worked closely with other partners including a homeless charity, children's centres and midwives to facilitate sessions in more accessible locations. This was intended to help remove negative connotations and stigma whilst making services more accessible to vulnerable groups and those most at risk.

Outstanding practice and areas for improvement

Outstanding practice

The service demonstrated a commitment to quality improvement and innovation. They participated in local and national research projects to further the understanding of the difficulties experienced by those partaking in substance misuse and its associated physical and mental health complications. This was achieved by establishing collaboration with key partners including, national substance misuse charities to help improve access to treatment for these groups.

Research and pilot initiatives explored the effectiveness of treatment for those with substance misuse difficulties and tackling the associated stigma in accessing timely and effective treatment to reduce health inequalities. The current research projects involved increasing the identification and treatment of hepatitis C, and of chronic obstructive pulmonary disease. The research was yet to be finalised, but preliminary findings suggested an increase in uptake of testing and treatment of these diseases.

The provider had an established team of registered general nurses to provide a health and wellbeing service across this and two other locations. This aimed to improve access to physical healthcare by having access to better help for clients with healthcare needs including wound management and monitoring of chronic conditions.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure it notifies CQC of all deaths of people using the service
- The provider should ensure it has processes in place to monitor and audit trail notifications and safeguarding alerts it raises so it is aware of how many and the detail regarding these, along with the progress of any associated actions.