Addaction - Barnsley, John Street

Quality Report

Addaction Harm Reduction Service
John Street
Barnsley
South Yorkshire
S70 1LL
Tel: 01226 289058
Website: www.addaction.org.uk

Date of inspection visit: 06 October 2016
Date of publication: 12/01/2017

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

Ratings

Overall rating for this location

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

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.

Summary of findings

Overall summary

We found the following areas of good practice:

- Clients gave universally positive feedback about staff. Clients told us that they thought that staff cared about their well-being beyond their use of substances and treated them like people. They told us they felt welcome at the service, safe and supported by staff.
- We saw that staff knew clients well and treated them with respect and compassion. When new health treatments became available for a medical condition staff contacted clients who had used the service to inform them of this and supported clients to access this treatment through local health services.
- Staff worked with agencies and in the local communities to increase awareness of the risks of substance misuse and the services and treatments available for people to access. We saw that this re-engaged some clients back into treatment for drug and alcohol use.
- Psychosocial intervention skills were used in brief interventions and groups including cannabis groups and fixed penalty groups.
- The service had a clinic room and a qualified nurse to deliver blood borne virus screening, vaccinations, basic wound and blood care. Emergency equipment was available and all medicines and equipment were in date.
- Staff had knowledge of safeguarding procedures and could explain how they responded to safeguarding concerns.

However, we found the following areas that the provider needs to improve:

- Clients' initial assessments identified risks in relation to the individual and their substance use. However, the care and treatment records for clients receiving brief interventions did not contain a risk assessment or risk management plan. We could not see how risks to clients using the service were being managed or mitigated.
- Care and treatment records did not contain a signed agreement to show if clients consented to sharing information and if they did consent what they agreed to share and with whom. However, staff and clients told us that this consent was agreed verbally.
- The supervision rate for staff was 67%. This had been identified through a quality audit visit by the provider. The provider had an action plan in place to increase the rate of staff supervision and ensure that all staff received regular supervision.
- Not all staff were up to date with all areas of their mandatory training.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services		Inspected but not rated.

Summary of findings

Contents

Summary of this inspection

Page

Background to Addaction - Barnsley, John Street 6

Our inspection team 6

Why we carried out this inspection 7

How we carried out this inspection 7

What people who use the service say 7

The five questions we ask about services and what we found 8

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards 11

Outstanding practice 21

Areas for improvement 21

Action we have told the provider to take 22

Addaction - Barnsley, John Street

Services we looked at
Substance misuse services

Summary of this inspection

Background to Addaction - Barnsley, John Street

Addaction Barnsley John Street is a harm reduction service in Barnsley. The service is delivered by the parent provider Addaction who are registered with the Care Quality Commission to provide services at 46 other locations. At the time of our inspection the manager was undertaking the application process to become the registered manager of the service. The previous manager had voluntarily deregistered because they had left the organisation.

Addaction Barnsley John Street is registered to provide the regulated activities of; treatment of disease, disorder and injury and diagnostic and screening. The service is commissioned by the Stronger Safer and Healthier Communities Directorate within Barnsley Metropolitan Borough Council.

The service provides:

- Specialist harm reduction advice including advice around safe injecting and checking injection sites for signs of infection.
- Needle exchange programme. The needle exchange provides clients with access to sterile injecting equipment and safe disposal of used equipment to reduce the risk of transmission of infections and disease.
- Triage assessment for new clients. An initial assessment of drug and alcohol use and exploration of readiness for treatment.
- Brief interventions and cannabis group. Brief interventions are opportunistic interactions where staff meet with clients and discuss motivation to change and engage in treatment for alcohol or drug misuse. The cannabis group is a short programme of group sessions aimed at increasing the awareness of the effects of using cannabis.
- Outreach work in the local community and with external organisations
- Blood borne virus clinics including screening and vaccinations. Staff also provide information and advice to clients about the risk of blood borne viruses. Blood borne viruses are diseases which can be spread through bodily fluids.
- Training to other professionals
- Fixed penalty notice group. This is where clients have been issued a fixed penalty notice with the requirement to attend an awareness group as an alternative to a fine or other legal consequence.

The blood borne virus clinic provided by Addaction Barnsley John Street provides the service for all clients across the treatment programme in the Barnsley area. Where clients require more structured treatment including substitute prescribing and detoxification, the service refers clients to a commissioned external organisation.

Addaction John Street works with adults aged 18 years and above who have a history of, or current, drug or alcohol issues. The service operates five days per week and opening times vary between 9am and 8.15pm.

The service was last inspected in May 2013 in accordance with the Care Quality Commission methodology in use at the time. The service met all standards at that inspection.

Our inspection team

The teams that inspected the service comprised of three CQC inspectors.

This inspection was led by Honor Hamshaw, Inspector, Care Quality Commission.

Summary of this inspection

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with the manager
- spoke with the operational manager
- spoke with four other staff members including project workers and a nurse
- reviewed 16 care and treatment records
- spoke with 13 clients that were using the service
- collected feedback from 16 clients that were using the service through comment cards
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

During our inspection, we spoke with 13 clients and collected feedback using comment cards from 16 clients who used the service. All comment cards gave universally positive feedback about staff and the service that was provided. Clients told us that when they visited Addaction John Street they felt safe and supported. They told us that staff were kind, supportive, non-judgemental and cared about their lives beyond their substance use. Clients also told us that staff provided them with information and took time to help them with any problems that they were experiencing.

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 found the following issues that the provider needs to improve:

- Care and treatment records for clients accessing brief interventions did not contain a risk assessment or risk management plan. We saw that initial assessments that staff completed with clients identified potential risks to the individual or others including staff who worked at the service. We could not see any information about how these risks were managed or mitigated.
- Not all staff were up to date with all areas of their mandatory training.

However, we found the following areas of good practice:

- Clients could see staff the same day for an initial assessment or for advice and information. The service had staff on duty each day to see clients who dropped into the service.
- The clinic room contained the equipment needed to complete blood borne virus screening, vaccinations and basic wound care. The service had emergency drugs and resuscitation equipment for used in an emergency. All equipment and medication was checked and in date.
- Staff understood their responsibilities in responding to safeguarding concerns and how to escalate these when needed.

Are services effective?

We found the following areas of good practice:

- Staff worked with a range of agencies and professionals to provide a multi-agency approach. This involved work in the local community to engage and support people to access information, treatment and harm reduction services for drug and alcohol use.
- Staff worked with local health services to promote new treatments for clients and supported them to access these.
- All care and treatment records contained a comprehensive assessment of clients' needs. These captured the clients' current and historical type of substance used and the route used.
- Brief interventions available included the use of psychosocial interventions which was in line with guidance from the National Institute for Health and Care Excellence.

Summary of this inspection

- Staff could explain how the Mental Capacity Act was appropriate and relevant when working with clients who accessed the service.

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

- The provider reported a staff supervision rate of 67%. This meant that some staff did not receive regular supervision. The provider had an action plan in place to ensure that all staff received regular supervision.

Are services caring?

We found the following areas of good practice:

- Observations of interactions between staff showed that staff were respectful, supportive and knew clients who used the service well.
- Clients gave universally positive feedback about staff. They told us they thought that staff cared about their well-being beyond their current or historical drug or alcohol use.
- Clients told us that they felt welcome, safe and not judged when they accessed the service.

However, we found the following issue that the provider needs to improve:

- Care and treatment records did not contain written consent to sharing information with others. Where clients gave verbal consent to share information there was no record of what information clients' consented to sharing and with whom.

Are services responsive?

We found the following areas of good practice:

- The service had an open door policy which enabled clients to access the service immediately during its opening hours. There was no waiting list and clients could speak to staff on duty and another staff member who operated the needle exchange programme.
- Staff worked in the local community to try engage prospective clients and re-engage clients who had disengaged from the treatment programme and harm reduction service.
- Clients could use a quiet waiting area which was private if preferred or needed.
- In the last 12 months the service received 19 compliments from clients who used the service.

Summary of this inspection

Are services well-led?

We found the following areas of good practice:

- Observations of staff working practices showed that staff displayed the organisations' values and behaviours in their work with clients.
- Systems were in place to ensure that staff received mandatory training, supervision and appraisal. The provider had identified that not all staff received regular supervision and had an action plan in place to increase the amount of supervision staff received.
- The service had experienced a period of change and there were some ongoing changes with the registered provider. Staff reported that this had cause a feeling of uncertainty within the service. However, staff understood the process and had been given information regarding changes to the service. Staff reported to feel supported by their managers and colleagues.
- Where key performance indicators were not met the provider had worked with commissioners and developed action plans to improve performance.
- Staff facilitated clients to take part in surveys completed by the Health Protection Agency.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

As part of our inspection we reviewed the adherence to the Mental Capacity Act and the Mental Capacity Act code of practice. The Mental Capacity Act is a piece of legislation which aims to maximise an individual's ability to make informed decisions and provide a process to safeguard individuals who lack capacity to make informed decisions for themselves. The Deprivation of Liberty Safeguards are part of the Mental Capacity Act but apply only to care homes and hospitals and are therefore not relevant to this setting.

Staff received online training in the Mental Capacity Act. The qualified nurse at the service completed face to face training in the Mental Capacity Act. The Mental Capacity Act was included in the provider's safeguarding policy and procedure. Staff told us that when they needed support with the Mental Capacity Act they could: refer to the provider's policies and procedures, speak to the operations manager or the qualified nurse for advice and support and contact local advocacy services

Staff completed an initial assessment of clients on their first contact with the service. Staff explained that clients who accessed the service could be under the influence of drugs or alcohol which could impact on their mental capacity to make decisions and to engage in the interventions provided. In some cases where clients were alcohol dependent, not consuming alcohol before attending the service could affect a client's mental capacity. The reason for this was due to the withdrawal effects of alcohol which could impact on clients' ability to process information and make decisions.

Where staff were unsure about the capacity of clients they told us they could speak to the qualified nurse at the service for support. Staff explained that they worked with clients to provide interventions when they were less intoxicated or more stable and had mental capacity to participate in interventions and make decisions.

Where clients' lacked capacity, staff involved other agencies such as, advocacy services, GPs and family members the client was comfortable with, to assist in making decisions. The operations manager also worked with the local authority social work teams to escalate concerns around clients who lacked capacity and were at risk from factors including, drug use, alcohol use, deteriorating mental health and homelessness.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

Access to the service for clients could only be gained during service opening hours. At other times the main entrance to the service was locked. The reception area was secure as a locked door prevented unauthorised access to the rest of the service. Reception areas had a glass partition between administrative staff and anyone in the reception area. The service had alarms fitted in all rooms with the exception of the administration area which was not accessible to clients. All staff knew what to do in response to the alarm sounding. Closed circuit television was in operation. This monitored outside and the inside of the reception area.

The service had a clinic room which was accessible by entering a code which only staff had possession of. The clinic room contained a secure fridge which held vaccinations. All vaccinations and equipment for basic wound and blood care was in date. Staff recorded fridge temperatures and records showed that these were within the required range for safe storage. The service did not have equipment for monitoring physical health as this was not part of the service provided. Emergency drugs were present and in date. These included adrenaline and naloxone. Naloxone is a medicine which can block the effects of opioid drugs and reverse the effects of an overdose. The service had resuscitation equipment which was kept in the administrator's office.

All areas were clean and well-maintained. A cleaning roster showed that cleaning was completed three times per week and infection control actions taken. The service had an external cleaning contractor. Hand washing facilities were available and in the clinic room. This included a sink with an elbow tap handle. This meant that staff delivering clinical interventions did not have to use their hands when operating the sink tap. This reduced the risk of cross contamination of bacteria and infections.

Safe staffing

The provider had established the staffing levels required through consultation with the service commissioners. At the time of our inspection the service had:

- One operational manager 30 hours per week
- One full time manager who was applying to become the registered manager
- One full time nurse
- Two project workers 30 hours per week
- One project worker 22.5 hours per week
- One administrator 14 hours per week.

In the 12 months leading up to 21 July 2016 the provider reported that there had been a 2% sickness rate and a turnover rate of 0%. The national average sickness rate is 5% and a 0% turnover rate meant that during that time that there had been no staff leave the service. The service had no vacancies. However, the service had received a reduction to their commissioned funding in the current financial year and as a result of this all staff had voluntarily reduced their contracted hours to accommodate this. This had been agreed with the service commissioners prior to implementation.

The average caseload per project worker for brief interventions was four cases per worker. This did not reflect clients who accessed the blood borne virus clinic or the needle exchange service. Managers told us that caseloads were small to enable staff to provide the cover the service. Each day, one staff member was required for duty and one staff member was required for needle exchange.

The service did not use agency staff. Staff told us that if this was required the provider would ensure that this was accessed in order to continue with adequate staffing for service delivery.

Mandatory training was mostly up to date. There were two training courses that were not up to date. These were medicines management at 50% and immunisations and vaccinations at 33%. The service had recently made these two training courses a mandatory requirement for staff. This was to ensure they had the correct training to be able to sign for vaccinations being delivered to the service and knowledge to discuss with, and offer vaccinations to, clients visiting the service. We saw that staff had training dates scheduled for this training

Assessing and managing risk to clients and staff

The service provided brief interventions, needle exchange and a blood borne virus clinic. Each part of the service kept records relating to the activity undertaken with clients. During our inspection, we reviewed 16 client records. These comprised of five client needle exchange records, five client blood borne virus clinic records and six records of clients that were accessing brief interventions.

At the time of our inspection there were 10 clients receiving brief interventions. We reviewed six of these care and treatment records. None of the records that we looked at contained a risk assessment to identify, mitigate and manage potential risks from, or towards, clients which included the risk to staff working with clients. We saw clients' initial assessments had identified potential risk factors which included: history of mental health problems, physical health conditions and depression. These did not provide any further information about how staff managed or mitigated these risks identified. During our inspection, we asked staff and managers about the absence of these risk assessments and they told us that at present there was not a risk assessment document in place. Managers told us that they were working to adapt risk assessments and safeguarding documentation to make this relevant to the service provided at this location.

Needle exchange records contained up to date brief risk assessments which explored the risks relating to drug use included injecting. Clients who accessed the blood borne virus clinic had a specific risk assessment which included known allergies, medication and previous vaccinations.

A full time nurse was employed by the service to provide the blood borne virus clinic. The nurse also responded to clients' other physical health needs when required. When clients attended the service with ulcers or lacerations the nurse completed basic wound care. The nurse also checked clients' injection sites and 'missed hits' at their request. 'Missed hits' are swellings around an injection site which are caused by fluid entering the tissue as the fluid has not entered the vein correctly or has leaked from the vein. Awareness of deep vein thrombosis was also discussed with clients who accessed the service. After the nurse had seen clients regarding their physical health the nurse signposted them to access services through their GP or to the accident and emergency department at the local hospital for further and ongoing care.

All staff had completed up to date training in safeguarding adults and children. The operational manager of the service was the safeguarding lead. Staff told us that they reported their concerns to the operational manager who escalated these to the local authority and within the organisation. Staff explained to us some of the indicators of safeguarding concerns which included self-neglect, homelessness and children. Where clients using the service had responsibility for children, staff were aware of their responsibilities of ensuring the safety of children and working with local authority children's services. In the 12 months leading up to our inspection, we received no safeguarding alerts or concerns in relation to the service.

Staff did not routinely visit clients in the community or at their homes. Staff told us that if this was required this would be completed in pairs. When working in the service staff could request assistance by raising the alarms fitted in each room. Should appointments continue longer than expected, or staff have concerns about staff working alone in interview rooms with clients, then a code phrase was in use for staff to covertly raise the alarm to their colleagues without raising concern to the client.

The service had a patient group directive in place to give the nurse at the service the authority to carry out vaccinations in the absence of a doctor on site. Patient group directives were signed and in date for naloxone, adrenaline and engerix b medications. Naloxone is a medication which can block the effects of opioid drugs and reverse an overdose. Engerix b is used to prevent hepatitis B.

Track record on safety

Substance misuse services

The provider reported no serious incidents in the 12 months leading up to 22 September 2016. In the same period the provider reported six unexpected or avoidable deaths which related to drug or alcohol related deaths. The provider was not found to have any responsibility or contribution to the circumstances surrounding these deaths.

Reporting incidents and learning from when things go wrong

Staff reported incidents using an electronic incident reporting system. Staff explained to us what types of occurrences they reported as incidents. The operational manager reviewed all incident reports and sent these to a central point within the organisation. The team discussed incidents at team meetings including any changes to practice. Staff felt supported by their manager and always received a debrief following any incidents. Managers told us that following incidents happening they could immediately lock down the service and meet as a team for support and to make decisions on the next steps to take.

The organisation was signed up to an employee assistance programme. Staff could access the employee assistance programme for any additional support or counselling they required.

Duty of candour

The provider had a policy and procedure on the duty of candour. Staff told us that where something went wrong this would be explained to the client and there would be openness and transparency in the investigation and explanation of what happened. At the time of our inspection staff told us that they had not needed to use this duty in practice.

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

Assessment of needs and planning of care

All new clients who accessed the service had an initial assessment completed with staff at first contact with the service. The initial assessment document gathered information including clients' personal details, substance misuse, vaccination status, mental and physical health, social and family functioning and history. The assessment explored current and historical substance use including the route that this was used. Staff told us that the information that they collected was what clients who accessed the service were able and willing to provide and so was not necessarily always fully complete or accurate.

Care records contained information relating to discussions and intervention that staff completed with clients who accessed the service. Clients who accessed brief interventions and/or the needle exchange service did not have recovery plans in place. Clients who accessed the blood borne virus clinic had a programme of course of care agreed with clients which included any hepatitis vaccinations and blood borne virus rapid testing.

An electronic record system was used by the service for needle exchange records and brief interventions. The records relating to the blood borne virus service were paper-based and stored securely. All staff had access to relevant records when needed.

Best practice in treatment and care

The service did not complete any prescribing. Staff signposted clients to their GP and local hospital for access to health services and treatments. When clients that were willing to engage in treatment and required substitute prescribing for opiate use or alcohol detoxification accessed the service, staff referred them on to the relevant service in the treatment pathway.

Guidance from the National Institute of Health and Care Excellence CG5: Drug Misuse in over 16s: psychosocial interventions states that in settings such as needle exchange services where clients have limited or opportunistic contact with drug and alcohol services that brief interventions should be offered to explore motivation to change and engage in treatment and information about self-help groups should be available. We found that the brief intervention provided at the service was in line with this recommended guidance. Clients could access brief interventions led by project workers. Staff completed these brief interventions using psychosocial intervention skills.

Staff supported clients who accessed the service with issues around employment, housing and benefits. Where more specialised knowledge was required, clients were signposted to and supported to access agencies in the community who could assist. These included local advice and help groups, housing providers and local authorities.

The initial assessment included information around physical healthcare needs. Staff asked clients if they were registered at GP surgeries and if not, signposted on how they can access these. After developments in physical health care provided by the NHS, a new treatment became available for people living with hepatitis c. The treatment was more effective in treating hepatitis c and has fewer side effects for people than previous treatments available. Staff at the service sent letters to previous and current clients with hepatitis c to ask them to contact the service. When clients contacted the service, staff informed them of the new treatment available for hepatitis c and with clients' consent supported them to be referred for the new treatment. During our inspection, some clients told us that they were receiving the treatment available for hepatitis c and without the service they would not have been aware of this.

The treatment outcomes profile was used by the service to measure outcomes. The aim of the outcome profile is to improve the treatment system for clients. Treatment outcomes were measured four times. These included: pre-treatment, review of treatment, post-treatment and exit post-treatment. The service completed the treatment outcomes profile for the period of time that the client was in contact with the service. Once a client progressed onto structured treatment at another service this was also transferred. The service provided their data to another organisation who reported this to the National Drug Treatment Monitoring Service. Staff told us that they were working with this organisation and their commissioners as the performance outcomes for the blood borne virus service were lower than expected. The service had an action plan in place to increase performance and ensure that the reporting reflected the performance of the service.

Audits took place and these included audits into blood borne virus clinic, medicines management and infection control. The provider also completed a quality visit to audit the service against Care Quality Commission requirements. The service had an action plan in place to increase the rate of supervision following this visit.

Skilled staff to deliver care

The team consisted of project workers and a nurse to provide the service. Staff were suitably qualified and experienced for the role that they performed. All staff had worked at the service some time and had completed the training required to enable them to perform the role required. Training in medicines management and vaccinations and immunisations was not up to date for some staff, however this had recently been introduced as a mandatory requirement and the service had expected timescales for when all staff would have completed this training.

The provider had an induction package which included orientating staff to the organisation through policies and training. In addition, the provider accessed additional training through the local authority to increase the training opportunities available to staff.

Staff told us that they received supervision monthly from their manager. The provider reported that between July and September 2016 the supervision rate for staff was 67%. It was detailed that staff postponed two supervision sessions due to other meetings and the service cancelled three supervisions due to other reasons not specified. However, staff told us that as the team was small they often sought advice and support outside of supervision when needed. Staff told us that the service had an action plan in place to ensure that the rate of supervision was increased. The qualified nurse received clinical supervision from an externally sourced provider. All staff received an annual appraisal of their performance.

Staff received additional and specialist training to support them in their role. Additional training that staff had completed included: motivational interviewing, drug and alcohol counselling, cognitive behavioural approaches, disguise compliance, international treatment effectiveness mapping, conflict management and dual diagnosis.

Managers told us that they would use the provider's policies and procedures to manage poor performance when appropriate.

Multidisciplinary and inter-agency team work

The service held team meetings every month. These occurred when the service was not open which meant that all staff could attend these meetings. Staff told us that they could add items onto the agenda to be discussed at team meetings.

Staff from Addaction John Street worked with a range of different disciplines and agencies to provide effective care and treatment to clients accessing the service and potential clients in the local community. Addaction John Street's premises were situated in the same building as

other organisations which provided dedicated carers support and advice and an organisation that provided free hot meals and food parcels to people in need. Staff worked with volunteers and paid staff from these organisations to access resources they provided for clients. Addaction John Street allowed the carers support service to use their premises free of charge to enable the service to continue due to funding difficulties as they valued the support provided to carers.

The service had links to other local recovery communities including mutual aid groups around alcohol and narcotic use. Staff provided clients with the details of these groups where appropriate. Staff worked with local colleges and organisations to increase employment and access to education and courses for clients who accessed the service. They explained that some clients had been able to gain voluntary and paid employment after accessing the service and building their skills. Staff told us that they regularly worked with housing and homeless shelter providers. This enabled them to access support for clients that were currently or at risk of homelessness.

Staff from the service completed outreach work at local gyms to encourage people in the local community to access the service for support with drug and alcohol use. This was aimed at raising awareness around the risks of using steroids and providing safe injecting advice, equipment and disposal. Staff also worked with inpatient mental health wards to provide information about the service for patients with dual diagnosis or patients close to discharge from the wards with issues around drug and alcohol use.

The service worked with the local authority and the police to gain intelligence and provide a presence in the local town centre to try and engage with people in the local area and support into treatment for drug and alcohol use.

Staff reported links with sexual health clinics, mental health charities, human immunodeficiency virus (more commonly known as HIV) support services, specialist hospital based midwives, GPs and hepatology specialists to provide multi-agency working to provide effective care and treatment.

Good practice in applying the Mental Capacity Act

Staff received online training in the Mental Capacity Act. The qualified nurse at the service completed face to face training in the Mental Capacity Act. The Mental Capacity Act was included in the provider's safeguarding policy and procedure. Staff told us that when they needed support with the Mental Capacity Act they could: refer to the provider's policies and procedures, speak to the operations manager or the qualified nurse for advice and support and contact local advocacy services.

The Deprivation of Liberty Safeguards are part of the Mental Capacity Act but apply only to care homes and hospitals and are therefore not relevant to this setting.

Staff completed an initial assessment of clients on their first contact with the service. Staff explained that clients who accessed the service could be under the influence of drugs or alcohol which could impact on their mental capacity to make decisions and to engage in the interventions provided. In some cases, where clients were alcohol dependent, not consuming alcohol before attending the service could affect a client's mental capacity. The reason for this was due to the withdrawal effects of alcohol this could impact on clients' ability to process information and make decisions.

Where staff were unsure about the capacity of clients they told us they could speak to the qualified nurse at the service for support. Staff explained that they worked with clients to provide interventions when they were less intoxicated or more stable and had mental capacity to participate in interventions and make decisions.

Where clients' lacked capacity, staff involved other agencies such as, advocacy services, GPs and family member the client was comfortable with to assist in making decisions. The operations manager also worked with the local authority social work teams to escalate concerns around clients who lacked capacity and were at risk from factors including, drug use, alcohol use, deteriorating mental health and homelessness.

Equality and human rights

The service collected information from clients during their initial assessment about their age, ethnicity, nationality, disability status, level of reading and writing ability and language spoken. This information enabled staff to be able to support clients with any needs pertaining to these areas. For example, whether they could read correspondence sent to them, if an interpreter was required and whether any reasonable adjustments were needed to enable clients to

attend appointments. The provider also reported anonymous information back to the commissioners of the demographics of client group accessing the service. Any person aged 18 or over could access the service.

Notices displayed at the service explained that the service did not allow the consumption of alcohol or drugs on its premises.

Management of transition arrangements, referral and discharge

The provider worked with another organisation who was commissioned to provide structured interventions, substitute prescribing and detoxification. Addaction John Street referred clients onto this service. Clients' accessing any service in the treatment programme could access Addaction John Street for blood borne virus screening and vaccinations.

Are substance misuse services caring?

Kindness, dignity, respect and support

During our inspection we observed staff interacting with clients, we spoke with 13 clients and we obtained feedback from 16 clients using comment cards. We saw that staff treated clients with respect and had an interest in clients' well-being. Staff had a non-judgemental approach when working with clients. At the time of our inspection the service had a caseload of 1375 clients. During our visit we saw many clients access the service. Staff knew clients and their needs well. We saw that staff knew all clients who entered the service by name and clients responded positively in return towards staff.

Clients told us that they thought staff treated them like people and cared about their lives not just about their substance use. They told us staff were caring, supportive, open minded, positive and polite. Clients said that when they visited Addaction John Street they felt welcome, safe and did not feel judged. They felt that staff took the time to see them and ask them how they were. Clients also told us that they could approach staff for support with any issues they were experiencing for help and advice.

We saw that Addaction John Street had posters which displayed information about confidentiality and information sharing. During our inspection we reviewed six records of clients that were accessing brief interventions.

We did not see evidence of written consent to share information in any of these six records. Records did not contain details to explain consent to what information and who they consented to sharing the information with. We saw one example where staff had shared information regarding a clients' progress with their employer. The record did not show that this had been agreed by the client. However, staff told us that the client had agreed verbally for information to be shared with their employer. Clients told us that staff discussed information about information sharing and their consent.

The involvement of clients in the care they receive

During our inspections we saw that staff involved clients in the service that they received. When clients accessed the service staff informed them of the services available. Staff encouraged clients to consider the treatment and harm reduction services available. However, the services that clients' accessed were each client's choice. Where clients were willing to engage in treatment this was supported and staff referred clients onto the service that provided structured treatment, substitute prescribing and detoxification. Where clients continued to use substances, staff provided information and equipment to promote the safer use of drugs and alcohol.

The service did not usually work alongside families and carers unless there was a specific need and agreement of the client. Staff accessed advocacy services when needed for clients. The service had information displayed about local advocacy services which clients could access.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Access and discharge

Addaction John Street had open door access. Anyone aged 18 or over with a history or current drug or alcohol use issue could access the service during opening times. Each day a member of staff was allocated as a duty worker. Their role was to be available for any clients that accessed the service for either the first time or clients open to the service. Staff could see clients on the same day to complete their initial assessment. Once an initial assessment was completed clients could access the services provided. If

clients required a referral onto structured treatment, substitute prescribing or detoxification this could be completed at the same time. At the time of our inspection 1375 clients used the service.

The service had set opening and closing times for clients. It operated week days between 9am and 8.15pm. The opening times each day varied. However, each week these were consistent times and clients told us they knew the times that the service opened each day. Clients told us they could access the service anytime it was open and staff were always available to provide what service they needed. Staff gave appointments for brief interventions, one to one sessions and for the blood borne virus screening and vaccination service. However, staff told us they saw many clients as and when they attended the service rather than by appointment times. Staff had a flexible approach as they knew that clients often had chaotic lives which did not always enable them to attend appointments or to be on time for appointments. Where clients did not attend appointments, staff made attempts to re-engage with clients. Staff provided clients with multiple opportunities to engage with the service. In the last 12 months, 618 clients did not attend planned appointments. Many clients accessed the hot food provision and food bank in the same building and this enabled staff to be aware of when they may see clients who had not attended appointments. The qualified nurse made time to be available during the hot food opening times so if clients would engage then that they had the time to see clients then.

In the last 12 months, 723 clients were discharged from the service. The organisation did not follow up on discharges routinely. Staff worked in the local community to try and engage with clients and promote treatment and harm reduction advice available to people. Staff told us that they sometimes saw clients who had disengaged with the service in the local community. Following staff speaking with them, some clients had then decided to re-engage with treatment through the service.

Staff told us that they rarely cancelled appointments. The service always had an allocated member of staff on needles exchange and another member of staff on duty. The operational manager told us when needed they worked delivering the service alongside project workers.

The facilities promote recovery, comfort, dignity and confidentiality

The service had a clinic room and other rooms where groups or one to one work could take place. There was also a quiet waiting room which was designated for use where clients preferred to or needed to wait somewhere private and quiet. Rooms had adequate sound proofing to ensure that any discussions that took place were private and could not be overheard by people outside. Furniture was soft and comfortable. Clients told us that they had been involved in helping with the decoration of the service.

We saw that information was displayed about the service on posters. Walls had posters which displayed information about different health conditions, information and advice leaflets were also available for clients to access. Addaction posters contained information about how clients could make complaints, what to expect of the service and what was expected of clients using the service, information sharing and confidentiality.

Meeting the needs of all clients

The service was accessible for people who required disabled access. Addaction John Street was on ground floor level with ramp access to areas set below floor level. The corridors were wide to allow wheelchair access. Staff told us that they could access leaflets and information in a range of different languages through Addaction. When needed, the service had used interpreter services. These had been sourced and funded by the provider.

Listening to and learning from concerns and complaints

In the last 12 months there was one complaint and 19 compliments about Addaction John Street. Clients that we spoke with could explain what they would do if they wanted to make a complaint and we saw that posters displayed information about how to make complaints. Staff told us that where someone made a complaint this would be dealt with initially by the operations manager who would ensure this was investigated and reported appropriately. Managers told us that the service commissioner also had a praise and grumble system where clients could share their feedback about the service directly to commissioners.

The service also had comment boxes and feedback boards where clients could give their feedback about the service and displays showed how this feedback had been used to

improve the service. Addaction's website also had a forum called "ask Simon" where people could send their comments to be considered by the organisation's chief executive.

Are substance misuse services well-led?

Vision and values

Addaction had organisational values and a values statement. The values statement said: "we empower people to be successful, to make positive changes and to take back control over their lives. We ensure that children, young people and adults are firmly at the heart of what we do and why we do it."

The organisation values were:

- Compassionate: we will not judge anyone that seeks help from our services. We will listen carefully to each person and respond to their situation with honesty and understanding.
- Determined: we believe that people can change with the right support and treatment. We will not give up on anyone and our staff will go the extra mile to achieve success for all our service users.
- Professional: all our staff are fully qualified to offer the best services to individuals and their families. We will always aim to continually improve our services and work in partnership with other agencies to ensure successful outcomes for all.

During our inspection, we saw that staff displayed Addaction's values in their behaviours and work practices. Staff knew that Addaction had values and how these related to their role working with clients.

Staff knew who their operational manager and service managers were. Addaction had an "ask Simon" function on the Addaction website. This enabled staff, clients and members of the public to pose questions or feedback to the chief executive of Addaction directly. Managers told us that the contracts manager and associate director visited the service recently.

Good governance

Systems identified any issues in staff receiving training, supervision and appraisal. Where issues were identified these were addressed. We found that there were two mandatory training courses that not all staff had completed. However, this was because these courses had recently been made a mandatory training requirement and all staff had dates scheduled for when they would complete this training. The supervision rate was 67%. Managers were aware that supervision rates were low and had an action plan in place to improve this area. Staff told us that they had access to live and ad hoc supervision when needed. All staff received an appraisal of their performance.

The team allocated tasks to staff and prioritised the direct service delivery above administrative tasks. Each day a member of staff was allocated to the needle and syringe exchange programme and a member of staff was allocated as a duty workers. The service had a volunteer administrator and a part time administrator to assist with admin tasks.

The service had an electronic incident reporting system. All staff knew how to report incidents. Staff completed audits into medicines management, blood borne virus service and infection control. The service had an internal Care Quality Commission mock quality audit completed to ensure the service was compliant.

Staff followed safeguarding procedures and adhered to the Mental Capacity Act code of practice when working with clients.

The service had key performance indicators which were set by the service commissioners. Managers had regular meetings with the commissioners to discuss the performance of the service against key performance indicators. The service was underperforming against key performance indicators for the blood borne virus service. An action plan was in place to address these performance issues. Managers told us that they thought that the data used to calculate performance may not be accurate as it is based on the data submitted to the National Drug Treatment Monitoring Service via the provider of the tier three services. We saw that part of the action plan was to work with this organisation to try and resolve this issue.

Staff and managers reported that there had been an incident and this resulted in a decision for the service to be withdrawn from the client involved. Staff and managers reported that in order for this to be agreed within the organisation, senior managers needed to be involved and this had taken a few weeks. Staff told us that they thought

that this should have been possible sooner and that the operations manager should have had the authority to do this. This had been raised by the team to Addaction. At the time of our inspection staff were not aware of any outcome of this.

Staff told us that they could escalate issues to their managers at any time. Managers reported that they sought support from senior managers when necessary. They also told us that they could raise issues to the clinical governance group. Items could be considered at clinical governance level for the risk register.

Leadership, morale and staff engagement

The service had a low sickness rate of 2%. The provider reported no cases of bullying or harassment. Staff knew how to raise concerns. They explained they would at first inform their manager and felt confident they would be able to do so. Staff told us that they could access the provider's whistleblowing policy if needed and would have no concerns in using this.

Staff told us morale was low. Staff said they really enjoyed their roles and working with clients and their team was the best part of their jobs. The commissioner had reduced the service's funding in the current financial year. As a team, non-clinical staff had decided that they would all voluntarily reduce their hours to meet the reduction in the service budget. This meant that staffs' contracted hours and salaries had reduced. In addition, the service had gone out to tender and Addaction had decided not tender for the service. This meant that by the end of the financial year a new provider would be responsible for the service. Staff reported that the uncertainty of the process had affected their morale but they understood and respected the position of Addaction.

All staff and managers reported a caring and mutually supportive team. Staff felt supported by their managers. Staff had worked as a team for some time and had developed positive working relationships. The operations manager had previously worked in the service as a project worker. Staff reported that there were opportunities for additional responsibilities and training to facilitate their leadership development. These included training in coaching and performance management.

Staff had been involved in improvements in the service delivery with the commissioners. An example of this was that staff were involved in redesigning the service's opening hours to reflect the change in funding. At a local level staff reported that the team had control to make changes in the service where this was identified as appropriate.

Commitment to quality improvement and innovation

Addaction John Street worked with the Health Protection Agency to support the participation of clients in the drug using survey. This was completed annually. Staff and clients participated in raising awareness for world aids day and Barnsley pride.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all clients have a risk assessment and risk management plan and ensure that all practicable steps to manage and mitigate risks to individuals and others are taken.

Action the provider SHOULD take to improve

- The provider should ensure that clients' care and treatment records contain written consent to sharing information with others. This should detail what information the provider can share and with which individuals and agencies
- The provider should ensure that all staff receive regular supervision.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not met: Care and treatment records for clients accessing brief interventions did not contain risk assessments or risk management plans. We could not see how risks to individuals or others including staff were managed or mitigated. Regulation 12 (2) (a) (b)