Addaction Recovery Centre - Roscoe Street Liverpool

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:

- Clients were positive about the service. They were provided with information about their treatment programme, and were treated with dignity and respect by staff.
- Clients had a comprehensive assessment of their needs, from which a recovery plan was developed. This addressed each client's drug usage, social, and physical and mental healthcare needs. Clients had a risk assessment, and their recovery plan incorporated these risks. Support and substitute prescribing was provided in accordance with national guidelines.
- There were enough suitably skilled staff to provide care and support for clients. Staff received supervision and appraisals, and had completed mandatory and additional training. The service had a medical lead/GP and a non-medical prescriber, with sessions from a second GP and a consultant psychiatrist. The service had community recovery champions, who were people who had used substance misuses services.

Summary of findings

- The service had introduced and participated in a number of research projects and pilots. These aimed to improve the physical wellbeing and health outcomes for clients.
- There were established pathways for referring clients to the service from the community detox services, GPs, the courts and the police. There were no waiting lists, and clients were usually seen within a few days of referral.
- Staff identified and responded to risks and concerns. This included safeguarding, unexpected exits from treatment, and incidents.
- Incidents, audits and complaints were reported, and reviewed locally and centrally.
- The service monitored its performance, and its impact on clients. Information about the performance of the service was provided to commissioners and to Public Health England.

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

- Recovery plans were not always written in a person centred way with clear goals.
- Information leaflets were not accessible to all people who used the service.

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

Addaction Recovery Centre - Roscoe Street Liverpool

Services we looked at:
Substance misuse services

Summary of this inspection

Background to Addaction Recovery Centre - Roscoe Street Liverpool

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

Addaction Roscoe Street is registered to provide the regulated activities: treatment of disease, disorder or injury; and diagnostic and screening procedures. The service has a registered manager, who is also the registered manager for Addaction Recovery Centre – South.

Addaction Roscoe Street provides a drug intervention programme, shared care with GPs, and recovery services. The integrated service provides open access to people seeking help with a range of illicit drug use. They provide opiate substitute prescribing (such as methadone) by referral only, as open access prescribing is provided by another organisation. Staff are linked with 28 GP surgeries, to provide shared care with GPs. The service also provides statutory drug assessments and support for police services and courts in Liverpool, and work with people when they are released from prison.

Addaction Roscoe Street is one of three Addaction recovery centres that provide services across Liverpool. Prior to April 2016 different services were provided from each of the different centres. However, the commissioners wanted an integrated service so that clients could access all or most services from each site. Staff training has been ongoing over a six-month period to give staff the necessary skills to work with all the different client groups.

Addaction Roscoe Street was last inspected by CQC in August 2013. No breaches of regulations were identified at the inspection.

Addaction Roscoe Street is owned and provided by a central company called Addaction, who provide around 120 services across the United Kingdom.

Our inspection team

The team that inspected the service comprised CQC inspector Rachael Davies (inspection lead), a second CQC inspector, and a CQC pharmacy inspector.

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?

Summary of this inspection

Before the inspection visit, we reviewed information that we held about the location, 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 four clients
- spoke with the registered manager
- spoke with seven other staff members
- looked at four care and treatment records
- carried out a detailed review of the medication procedures
- 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 were treated with respect by the staff, and felt they were treated as equals and not judged. Clients knew what their care plan was, and were able to contact their keyworker when they needed to.

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 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.

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

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. There were routine environmental and cleanliness checks carried out, and any problems addressed. Waste was disposed of safely.
- There were enough suitably skilled staff to provide care and support for clients. Recruitment was in progress for staff vacancies. The service had a medical lead/GP and a non-medical prescriber, with sessions from a second GP and a consultant psychiatrist. Staff had completed their mandatory training.
- Clients had a risk assessment, and their recovery plan incorporated these risks.
- Staff knew how to identify 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 or missed collections.
- Staff were clear about the action to take if a client unexpectedly left treatment.
- Staff knew how to report and escalate incidents. These were reviewed locally and corporately and any required action taken.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients had a comprehensive assessment of their needs, from which a recovery plan was developed. This addressed each client's drug usage, social, and physical and mental healthcare needs.
- Support and substitute prescribing was providing in accordance with national guidelines.
- The service had introduced and participated in a number of initiatives to improve the physical wellbeing and health outcomes for clients.
- Staff received regular supervision and appraisal. Staff had received additional training to carry out their role.

Summary of this inspection

- The service had effective links and care pathways with other organisations such as GP practices, pharmacies, the police and the criminal justice system.
- Clients were asked for their consent to share information with others.

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

- Recovery plans were not always written in a person centred way with clear goals.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients were positive about the service. They knew what their treatment plan was, and signed their agreement with this. They were treated with dignity and respect by staff.
- Clients were provided with information about the service. Their initial assessment included information about what the service provided, and the expectations of the client. The plan was discussed at each one-to-one review.
- Information leaflets were available on a range of subjects. This included information about specific drugs and health conditions, to dealing with symptoms such as cravings, to accessing support for other issues such as welfare advice or domestic violence.
- The service had community recovery champions, who were people who had used substance misuses services.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients had access to the service. There were no waiting lists, and clients were usually seen within a few days of referral. There was an activity programme available five days a week, with a range of diversional and therapeutic groups. The main service was opened during weekdays and one evening a week.
- There were established pathways for referring clients to the service from the community detox services, GPs, the courts and the police.
- The provider carried out our statutory assessments of clients at court and in police custody suites. This service was available in the evenings and at weekends.

Summary of this inspection

- The service was near the centre of Liverpool, and was accessible to clients. The building was clean but would benefit from refurbishment. There were active plans to move to a large and more suitable building. Clients met with staff and had drug screens carried out in private rooms.
- The service had a complaints policy, and information about to make a complaint was on display in the building.

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

- Information leaflets were not readily accessible for clients who may not speak fluent English, or have other communication difficulties.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff were aware of Addaction's vision and values, and reflected them in the care they provided. They were incorporated into the supervision structure.
- The service monitored its performance, and its impact on clients. Information about the performance of the service was provided to commissioners and to Public Health England.
- Incidents, audits and complaints were reviewed locally and centrally.
- The organisations policies were available to all staff.
- Changes within the service had created uncertainty, but staff were mostly positive about the service and the support they received.
- The service was part of a number of innovative research projects and pilots that aimed to reduce health inequalities, and improve outcomes for clients.

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. Staff were aware of considerations around capacity and consent. All clients were presumed to have capacity to make decisions about their treatment. As such, staff did not carry out a formal capacity assessment of all clients. However, if they had concerns about a person's ability to make decisions they would delay the decision making process or refer them to the doctor to assess their health and their capacity to consent. This may occur if a client appeared to be very intoxicated.

The service had not been involved in any Deprivation of Liberty Safeguards applications.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

The building was clean but worn. There was damp on the walls in the group room, which staff told us had been inspected and was not hazardous to health. The service and commissioners had identified that the building was not ideal for its purpose, and there were active plans to move the service to a different site. A larger and more modern building had been identified, and plans were in progress to confirm the move and fit out the new building. The manager told us that they hoped to move before the end of 2016.

The service had a dedicated room for drug testing, with a toilet next door to it. Drug testing kits were used which tested for several drugs at once. The testing room was equipped with facilities for handwashing and had equipment for the safe disposal of testing kits. There was not a needle exchange service at the site, but there were syringe/needle pick up kits and body-fluid disposal kits. This meant they disposed of sharps safely, which reduced the risk of sharp-related injuries.

There were cleaning schedules for the daily, weekly and monthly cleaning of the building. Addaction employed an external company to provide the cleaning service. They also carried out an audit each month, which had highlighted some minor issues that had been addressed. The cleaning cupboard contained different coloured mops for different parts of the building (such as corridors and toilets). This was in accordance with accepted infection control standards. There was a list of control of substances hazardous to health (COSHH) information, and appropriate storage of control of substances hazardous to health such as cleaning products.

The provider had a health and safety handbook and toolkit. This included policies and checklists related to health and safety, accidents and incidents. A health and safety assessment had last been carried out in July 2016. This asked questions related to a number of areas, which included manual handling, fire, utilities, waste disposal and infection control. No significant issues had been identified.

The fire policy contained information for staff about the safe management and evacuation of the building in the event of a fire, including fire zones and maps. There were fire exit signs and information around the building. Fire risk assessments had been carried out as part of the health and safety assessment. Addaction's policy required a fire drill to take place at least once a year, and one had last been carried out in February 2016. The findings showed this had been completed slightly quicker than the previous drill. Staff had completed fire training. There were fire extinguishers in the building, and they had last been serviced in April 2016.

There were first aid boxes around the building. These were in date, contained a list of contents, and were routinely checked. Three staff had completed first aid at work training in August 2016 and this was valid for three years. There were qualified first aiders on duty.

Computer workstation assessments had been carried out in July 2016. Annual tests of portable electrical items had last been carried out in November 2015.

There were urgent assistance alarms in each of the interview rooms and around the building. A panel indicated which room or area an alarm had been activated in, and staff attended. Staff confirmed that the alarms were rarely used. Staff told us that clients could potentially be aggressive or agitated, but this was usually de-escalated.

Safe staffing

Substance misuse services

Up to the 13 May 2016 there were 20 substantive staff who worked at Addaction Roscoe Street. Three staff had left, which gave a staff turnover of 15%. At the time of our inspection there was one recovery/keyworker vacancy at Addaction Roscoe Street. Interviews for this were taking place the week after our inspection.

In the 12 months up to 13 May 2016 there had been 506 days of absence, 175 of these were from long-term sickness. There was a clear process for managing absence, and supporting staff with long-term sickness. Addaction had access to an occupational health service.

Recruitment checks were carried out on all staff before they started working in the service. This included police checks and references, which were carried out by a central Addaction business team. Staffing working with the police, courts and prisons had additional police/prison clearance.

Staff told us that the staffing levels were usually adequate, and they did not run short staffed. Occasionally staff would cover across the three recovery services. Bank or agency staff were not used.

The clinical lead for the three Addaction Recovery Centres was a GP, who was also the head of mental health at a clinical commissioning group. They were not involved in the commissioning of substance misuse services. An addiction psychiatrist and a GP prescriber provided evening sessions and additional cover when required. A pharmacist was a non-medical prescriber, and carried out most of the prescribing clinics. They also prescribed for clients who were registered with GPs that did not have shared care agreements with Addaction. There were two counselling staff who were based in Croxteth, but worked across all three recovery centres.

The service was still in transition from the previous way of working, so there was some overlap of staff roles. Prior to April 2016 there had been specific staff doing drug interventions, shared care with GPs, and criminal justice/court diversion roles. This was moving towards a generic recovery/keyworker who carried out all or most of these roles.

The service had recently employed a registered general nurse as a health and wellbeing nurse, and a second was due to start shortly after our inspection. They had been employed to improve the physical healthcare of clients.

Addaction ran a volunteer programme, which was coordinated from another site, but the volunteers worked at various Addaction services. There were two intakes of volunteers a year. When Addaction had a surplus of suitable volunteers, they referred them on to other local volunteer services. Volunteers had the same recruitment checks as permanent staff, and went through an induction during which their interests and skills were assessed. The role varied for each volunteer, but included meeting and greeting clients, administration, and seeing clients with supervision from permanent staff. The role usually lasted for six months but could be extended.

Mandatory training was completed online e-learning and included safeguarding children and adults, health and safety, equality, information governance, and infection prevention and control. There was a training dashboard for all staff, and their managers, which clearly showed if training had been completed. Mandatory levels were at 97%, as all but one member of staff had completed all their mandatory training.

Following the reconfiguration of the service, all staff had completed, or were in the process of completing, a six month training programme to ensure they had the necessary skills to work with all the client groups who visited the service.

All new staff had an induction. As part of this they had a 'buddy' on the staff team, and they shadowed staff providing clinics.

Assessing and managing risk to clients and staff

All clients had an up to date risk assessment and a recovery plan, which reflected the client's risks. An initial assessment was completed with details of the client's history and needs. This included their drug use, social, and physical and mental health. It included potential risk areas such as any history of overdoses, known health problems, blood borne viruses, injecting sites, and criminal justice information. The risk assessments were reviewed every 12 weeks. The electronic notes system flagged up when reviews were due or overdue. These were routinely monitored in supervision, so a keyworker's line manager could see if there were any gaps or delays.

Clients referred to the service for treatment were managed by either the service or, more commonly, via a shared care arrangement between the service and the client's GP practice. Clients' treatment needs were assessed at the

service by a doctor or non-medical prescriber. They were accompanied during consultations by the key worker who knew the client well and oversaw their ongoing treatment. Consultations included an assessment of treatment needs and goals, physical, mental health and social issues. Clients were prescribed buprenorphine or methadone depending on their requirements. Clients could also be prescribed other medicines to manage their withdrawal symptoms. At some appointments clients were asked to provide a urine sample and were screened for illicit drug use. Blood borne viruses were discussed and clients were asked if they had been tested for hepatitis B and C. Lockable boxes were provided for clients to store their medicines safely at home if needed, for example, if they had children living at home with them.

Medicines were not stored at the service. Prescriptions were issued for clients to take to their chosen pharmacy. Clients could potentially choose from 138 pharmacies, but there were preferred options that staff had good relationships with. The pharmacies informed the service if there were problems such as missed collections or missing prescriptions. Staff assisted clients with information on which pharmacies were open seven days a week in the area if this was needed. There was a documented auditable process for the management of prescriptions, including the storing, issuing, logging and destruction of prescriptions. The medical team followed Addaction's corporate medicine management policies and formulary and relevant national guidance for the prescribing of medicines. The non-medical prescriber at the service was a pharmacist, and they were overseen by the clinical lead for the service as set out in Addaction's non-medical prescribing policy. They received monthly newsletters on medication issues from the Addaction area pharmacist.

Staff knew how to identify and respond to safeguarding concerns. The service had local and corporate safeguarding policies, and information and flowcharts about safeguarding were on display in staff offices. There was a safeguarding lead within the service, and a clear process for recording, reporting and escalating concerns.

As part of assessment process, there was a standard safeguarding form that staff completed, that included prompts of staff to consider. The safeguarding lead and team leader or manager reviewed the completed form, and ensured that any required action was taken.

The safeguarding form asked for details of any offending behaviour (particularly for people referred from prison, or through criminal justice system), in additional to information gathered about drug and alcohol use, and details of mental and physical health. All clients were asked for details of any children they had, which included their ages, where they lived, if social services were involved, and if there had been any domestic violence. Safe storage of medication, particularly away from children, was discussed as part of the assessment process.

Staff told us that safeguarding referrals were rarely made as other agencies, including social services, were often already involved with their clients. The service had established links with social services. Staff said they knew how to escalate safeguarding concerns to their manager, and that they knew how to make a direct referral to the local authority if required.

Clients did not have an individual plan for unexpected exit from treatment, but this was discussed at their initial assessment. Staff had a process for following up clients when they unexpectedly left treatment, which included an unplanned exit checklist. Staff told us that unexpected exits tended to happen less with shared care clients, and were more common if a client moved out of the area or went back to prison. During the initial assessment clients were asked for the details of a range of family, friends and other contacts. For example some clients may be seeing a probation officer, or have mandatory bail conditions that linked them to a person or an address. The assessment would take account of the individual's circumstances, and the response would be different if a client was stable with an established GP, to a client who was engaged with the criminal justice system.

Track record on safety

There had been no serious incidents at the service within the last 12 months.

Reporting incidents and learning from when things go wrong

The service introduced an online incident reporting system in March 2016. Staff knew how to identify and report incidents. Incidents were reviewed by managers who followed up the reports and any actions, and then sent them to the central incident team for review.

Substance misuse services

The most common types of incidents involved prescriptions. For example, if a client had damaged or lost their prescription. These were reviewed, and timescales for investigation and action monitored.

When a client died, this was reported as an incident. It would be discussed at a central drug related death meeting, which was hosted by commissioners in Liverpool, and involved agencies involved from across the area. Staff from the service would provide a summary of care, with oversite by the central Addaction quality team, who may also review the client's records.

Incidents were reviewed and analysed by the national Addaction critical incident review group. They collected information about incidents, from across all Addaction's services, and looked for trends. Lessons learned, either locally or nationally, were shared through emails sent to all staff, or e-bulletins were sent to managers to share in team meetings.

Staff told us they felt supported by managers, and the culture of the organisation was supportive rather than punitive. There was access to a counselling service for staff following serious or traumatic incidents.

Duty of candour

Staff understood their responsibilities with regards to the duty of candour. There were no recorded incidents of a level that met the criteria for a formal apology. Staff were open with clients about their care and treatment.

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

Assessment of needs and planning of care

Clients had a comprehensive assessment of their needs. This included a detailed assessment of the client's drug and alcohol use, risk, mental and physical health, and social needs. The service used its own "Addaction Liverpool Universal Assessment" pack. This was an extensive assessment of the client's history and needs, and had been updated since the reconfiguration of the service in April 2016 so that all staff were using the same assessment tool. Clients' records were stored in an electronic records system.

Clients had a detailed assessment of their drug and alcohol use. This included the drug(s) they were using, how much and by which route. They were asked about their previous access to treatment, and assessed and screened for blood borne viruses such as hepatitis and HIV. They were provided with harm reduction advice, and assessed for their motivation to change.

Clients had a physical healthcare examination, and were advised and supported with their physical healthcare where necessary. If a client had physical healthcare concerns they were referred to the physical healthcare nurses now working within the team. For example to review ulcers or to change dressings. For anything the staff were not able to deal with directly, they advised the client to visit their GP and supported them to make an appointment.

Smoking cessation was provided by GPs. For sexual health advice staff supported clients to access other services. The manager told us that the commissioners in Liverpool tried to avoid duplication of services, so had clear pathways for the provision of these services.

Care planning started by asking about the client's goals for treatment, any changes they had already made, and their key strengths. All clients had a recovery plan, which was reviewed at one-to-one sessions. Information and a contract for care were signed as part of the assessment and planning process. This included the expectations of the client and the services. Clients had signed their recovery plans. The recovery plans were individualised, but were not written from the perspective of the client, and did not always show clear goals. For example, one plan said "engage with housing" and another "explore hobbies". The provider had carried out an audit, which identified that improvements were required in how the recovery plans were written. This was part of the service's plan following the reconfiguration of the service. At each appointment the client and staff member signed against the date for the next appointment.

Best practice in treatment and care

Staff followed Addaction's corporate policies for the management of substance misuse, which reflected national guidance. This included the 'Drug misuse and dependence: UK guidelines on clinical management' (Department of Health, 2007); and 'Methadone and buprenorphine for the management of opioid dependence' (National Institute for Health and Care Excellence (NICE), 2007).

Substance misuse services

The National Treatment Agency commissioned the Strang Report, published in 2012. This emphasised the need for drug and alcohol services to focus on recovery, which included supporting clients to improve their health and social functioning. Clients at Addaction Roscoe Street had a recovery plan, and were supported with their health and social 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. Some staff had training in motivational interviewing and cognitive behavioural approaches, which they used in their sessions with clients. Staff supported clients with practical issues such as benefits and housing.

The Strang Report also recommended the use of peer mentors to support clients with their recovery. Addaction Roscoe Street employed recovery workers, who were stable in their own treatment, and were trained and supported to work in the service.

Clients had their physical healthcare needs assessed. The service had recently employed a registered general nurse, and was in the process of recruiting a second. Their role was to work as health and wellbeing nurses, to improve clients' access to physical healthcare. 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.

A domestic violence worker had worked in the service for 12 months. The worker supported staff to develop their skills and knowledge when working with clients involved in domestic violence.

Skilled staff to deliver care

All staff had completed an annual work performance appraisal. This was completed annually and was reviewed in supervision. The appraisal template linked into Addaction's corporate objectives. Staff had a training needs analysis completed, which showed the training staff had completed, and any mandatory or further training they required. The sample of records we looked at showed that plans developed at appraisal were implemented through the year. For example, a staff member needed specific training to carry out an additional role. The training was completed over several months, and the staff member carried out this additional role.

All three doctors who worked in the service were up to date with their revalidation requirements.

All staff received regular supervision. Caseworkers aimed to have supervision every six weeks. The advanced practitioner provided supervision for recovery champions and peer support workers. The sample of three staff records we reviewed included evidence of regular supervision. This included discussion of workload such as the number of referrals and detailed caseload monitoring (number of appointments offered, attended, did not attend, and discharges). Specific client issues were discussed, in addition to recording and updating of records. Training needs were identified when necessary. Staff were able to address any workload/team issues, 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. Some staff had had training in psychological-based techniques such as clinical behavioural analysis. Some staff had had specific training in working with people affected by domestic violence. A domestic violence worker had worked in the service for 12 months, and supported staff to develop their knowledge and skills in this area.

Multidisciplinary and inter-agency team work

Staff from the service had links with other agencies built into their role. Staff had dedicated links with GP practices to provide shared care for clients, which incorporated support for the client and prescribing arrangements. Staff assessed clients in the custody suites, and at or referred from the courts. They had inreach services to local homeless services.

The service linked in with community mental health teams, and other community services where necessary. The local mental health trust were commissioned to provide some drug services within the area.

The service had been part of a pilot for identifying and working with clients with Hepatitis C, which was run by a local acute NHS hospital.

Substance misuse services

The clinical lead ran Royal College of GP courses across Addaction Roscoe Street, and the other Addaction recovery services in Liverpool. The service had provided training for an organisation working with asylum seekers. The service provided placements for social work students.

Good practice in applying the Mental Capacity Act

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 not been involved in any Deprivation of Liberty Safeguards.

The staff we spoke with had an understanding of capacity and consent, and described an occasion when they had carried out a capacity assessment because of concerns about the client's ability to consent. All clients were presumed to have the capacity to make decisions about their treatment. 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 may 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.

Clients were asked for their permission to share information with others during their initial assessment. This included their GP, and other statutory bodies such as the Driver and Vehicle Licensing Agency. Clients were asked for details of family and friends that the service could contact if the client was unavailable.

Equality and human rights

There was an equality and diversity policy. Equality training was mandatory, and all staff had completed this within the last year. Each client had a care plan based on their individual preferences and needs.

Management of transition arrangements, referral and discharge

There were clear pathways for shared care with GPs, from the community detox services, and from the courts and police.

Shared care for prescribing was supported by link staff from Addaction Roscoe Street holding routine clinics at GP surgeries. Clinical letters were sent to GPs following prescription reviews.

Are substance misuse services caring?

Kindness, dignity, respect and support

Clients knew what their treatment plan was, and 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 treated as equals and not judged. They were able to contact their keyworker when they needed to, and felt that staff were supportive, and spent time with them. The interactions we observed between staff and clients were positive and respectful.

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

Clients 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.

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

The involvement of clients in the care they receive

As part of the initial assessment, clients were asked about their history and their motivation to change. They were provided with information about the programme, and a contract of what is expected of them. For clients on opiate substitute prescriptions this included details of how this worked. The service focused on harm reduction and recovery focused care. Clients were encouraged to reduce or stop their substance misuse, but were not told they must do so. Clients met with staff, and the plan of care was reviewed at each session. Clients signed their agreement with their plans.

Information leaflets were available about a range of subjects. This included about specific drugs, specific healthcare conditions (such as hepatitis), harm reduction, dealing with specific symptoms such as cravings, and recovering from a previous relapse. There was also information about specific prescribed drugs used in substitute prescribing and detox. Information was provided about how to access support for domestic violence or welfare advice.

The manager told us that Addaction used to carry out an annual survey of clients and staff. However, this year they

had changed how they do this, and had employed a service user/advocacy group to carry out events with clients and staff. These focused on talking with people face to face, rather than through a form. The service was awaiting feedback from these events.

The service had community recovery champions, who were people who had used substance misuse services. 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, but may involve meeting and greeting clients and participating in meetings.

Clients sat on interview panels. The manager confirmed that a client was on a staff interview panel the week after the inspection.

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

Access and discharge

On the 13 May 2016 the service had a caseload of 329, with an average of 186 clients seen per week. The shared care intermediate staff had caseloads of 77 and 72, and the criminal justice staff had caseloads of 31-34. The remaining keyworkers had an average of three clients each, as they were mainly assessment workers. At the time of our inspection the provider told us that the overall caseload was 799. This was higher because of reconfiguration across the three recovery centres. Caseloads had also increased from between 45-86 clients.

The service opened from 9am to 5pm from Monday to Friday, and there was one evening clinic each week. The evening clinic tended to be used by shared care clients who needed flexibility because of jobs or childcare. Staff told us they had tried opening at weekends in the past, and kept this under review, but it had not been well attended.

People were encouraged to go to whichever of the three recovery centres was nearest to them. However, there was flexibility in this as clients may find it problematic to visit the centre in their local area because of stigma or local relationships.

Clients typically visited the service for a review with their worker every four weeks. Information for the 12 months up to 13 May 2016 showed that clients did not attend 1733 out of 9733 appointments offered. All clients who did not attend were followed up by phone call or letter on the same day.

Most non-criminal justice clients were referred from the Mersey Care community detox service. Addaction Roscoe Street was part of an established care pathway. When a referral was accepted, a date was agreed to meet the client, which was often the following working day. There was no waiting list.

Occasionally GPs referred clients directly to the service. There were agreed processes for accepting clients through this route, and it was clear who was responsible for care, and may include joint assessments between the service and GP. There was no waiting list for clients, but they may have to wait a few days for the next available clinic or session.

Clients released from prison would be seen straight away. Staff were based in the courts and custody suites and carried out assessments the same day.

There were clear shared care arrangements between Addaction Roscoe Street and GP practices. Staff were linked to 28 GP surgeries, and each shared care worker had several surgeries they worked with.

The service provided statutory drug assessments and support for police custody suites and courts in Liverpool. Addaction had dedicated workers at the courts and in police custody suites. They saw all clients who tested positive for opiates and cocaine, and carried out statutory "required assessments", which were fed back to the courts.

The facilities promote recovery, comfort, dignity and confidentiality

The building was clean, but worn in places. There were active plans to move to a larger and more suitable building. The manager confirmed that this and the new building were accessible to their client group because of the catchment area, proximity to the courts, and easy access for others by being in central Liverpool.

There were four interview rooms on the ground floor. They were private and had information leaflets available, and posters on display. One of the rooms had a computer that could be used by clients. There was a private consultation room for medical reviews. There was a reception and waiting area.

There was a supply of non-perishable food, so that staff could give food parcels to clients if necessary. This was supplied by a charity that collected food that would otherwise be wasted from the food industry, and redistributed it to organisations serving vulnerable and homeless people.

There was a five day activity programme. Groups included mindfulness, music (which included guitar and drums), creative writing, support and training to help people get a job, and local walks. There were specific groups around health issues such as hepatitis C, and support groups for clients who used specific drugs.

Meeting the needs of all clients

Information leaflets in the service were only available in English. Staff told us they could provide information in other languages if necessary. The manager told us that although the local population was diverse with a multitude of cultures, most people spoke English. The service had done inreach work with local mosques, to raise awareness of substance misuse and the service available to support people.

The building was wheelchair accessible, and most of the client facilities were on the ground floor of the building.

Listening to and learning from concerns and complaints

The service had received no complaints over the previous 12 months, and had received 30 compliments.

The complaints policy was on display around the building. Clients told us knew how to make a complaint if they wanted to. Staff were aware of the complaints policy and how to respond to complaints. The manager told us that clients may ask to speak to the manager if there were issues they were unhappy about. We saw an example where a client was unhappy about their prescription, which had been logged as an incident, reviewed, discussed with the client and resolved.

Are substance misuse services well-led?

Vision and values

The values of the organisation were to be compassionate, professional, determined and effective. These were supported by Addaction's guiding principles which were to be resilient, inspiring, collaborative, ethical and self-challenging. The organisational aims and objectives were to retain contracts and obtain new ones, train and develop staff, and strive to improve performance for clients.

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. They were also at the top of the supervision template, that staff completed at each supervision session.

Good governance

The data lead collated information from all the recovery centres to send 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 client's who used substance misuse services. The information measured the progress of individual clients, and built a national benchmark of how services were impacting on the lives of people within drug and alcohol services. Addaction Roscoe Street had collected and submitted this information as required.

The way the service reported to commissioners had changed, and moved from quarterly contract to monthly exception and quarterly themed reporting. The most recent information was from April to June 2016, and was an interim report that showed there had been no decrease in performance since the start of the new contract in April 2016. The data administrator collated all the relevant information each month. The managers spent a day with the commissioners, as part of the business planning process. The service and its commissioners were working together to build a new performance management framework, which was expected to be completed within two months. This aimed to provide summary and detailed reporting to commissioners.

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 Quality and Clinical Governance provided clinical and medical leadership to the organisation, and was led by the medical director.

Substance misuse 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 that the recovery plans were not clear and did not always include timescales. The service had recently received the audit, and was developing an action plan.

Policies were stored on the service's shared computer drive, 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 service, 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. There had also been a change in management. Staff told us this had led to uncertainty, but they found managers supportive and felt the service was now settling down. Staff had mixed views about how involved or informed they felt about the changes. Staff were aware that the service would be moving to a different building, but felt this would be an improvement on the existing building.

Staff felt they could speak out about the service. Staff meetings were taking place, but had been sporadic during the transition since April 2016. Staff had had one-to-one meetings and supervision with the managers and team leaders. They gave feedback about the service as part of their supervision.

The manager told us he felt supported to do the job, and could speak out about any concerns or suggestions for improvements. They were also involved in wider projects within the Addaction group.

Addaction had a corporate risk register. The registered manager told us that they did not have access to it directly, but they could add risks to it. At the time of our inspection the main issue of concern was the building, which had been raised by commissioners as not being fit for purpose. There were well-progressed plans to move to a more suitable building, hopefully by the end of the year. There were no high or outstanding issues on the risk register for Addaction Roscoe Street.

Commitment to quality improvement and innovation

The service was part of two research projects that aimed to reduce health inequalities. They were based on a pilot-project from 2013, which included an Addaction clinic and three shared care practices. This had shown that although people with addictions were less likely to engage with healthcare services then the general population, they were likely to attend appointments with their keyworker to pick up prescriptions. As such, they were more likely to attend for healthcare appointments and screening if these were co-located with their addiction keyworker.

One of the research projects was called HepCATT. 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. This had increased the uptake of treatment by clients following testing.

The second research project was called SprioSC, and was related to high rates of undiagnosed chronic obstructive pulmonary disease in the client group, and uptake of spirometry in Liverpool's shared care practices. Spirometry is a diagnostic test that can be used in the diagnosis of chronic obstructive pulmonary disease. 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.

The service had employed a domestic violence worker as part of a 12-month project. The purpose of the role was to advise and support staff so that were better equipped to support clients in this position. The service implemented an assessment tool for use with the victims of domestic violence, which was included as part of the universal assessment pack. The worker was no longer at the service, but staff told us they had found them very helpful, and it had helped them support and signpost clients to deal more effectively with domestic violence.

Outstanding practice and areas for improvement

Outstanding practice

The service had participated in two research projects that aimed to reduce health inequalities. Previous research, including a pilot involving Addaction in 2013, had identified that their client group tended to be less likely to engage with healthcare than the general population. However, they were likely to attend for appointments with their substance misuse worker to collect their prescription. The pilot found that clients were more likely to engage with healthcare if it was co-located with their substance misuse worker. 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 service had employed a domestic violence worker for 12 months. This had improved the knowledge and skills of staff when working with clients who were the victims of domestic violence.

The service had employed a registered general nurse, and was in the process of employing a second, as a health and wellbeing nurse. This aimed to improve access to physical healthcare by having qualified nurses on the premises.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that recovery plans are person-centred and have clear goals.
- The provider should ensure that information leaflets are accessible for all clients who used the service.