Addaction - Rugby

Quality Report

The Recovery Partnership
1 Regent Place
Rugby
CV21 2PJ
Tel: 01788 569582
Website: www.addaction.org.uk/services/recovery-partnership-rugby

Date of inspection visit: 13 July to 18 July 2016
Date of publication: 19/10/2016

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 standalone substance misuse services.

We found the following areas of good practice:

- Clients who used the service were very positive about staff. Some clients linked their reduction in substance misuse to the support staff had provided. Clients felt staff listened to them and treated them as partners in their recovery. Clients described staff as caring, attentive, supportive and good listeners. The service routinely gathered feedback from clients and looked at ways they could change things as a result of client suggestions.
- Clients were assessed and treated in a timely manner. There were no waiting lists. Clients received a holistic assessment which looked at all of their needs. Medical staff carried out a physical examination and communicated with clients' GPs before prescribing medication. The service had a robust policy for re-engaging with clients who had missed their appointments.
- Staff began the risk assessment process as soon as they met with clients. They developed risk management plans when they felt these were required.Staff were able to identify when there may be safeguarding concerns for adults and children

Summary of findings

and they knew how to report these to the local authority. They understood mental capacity and how to support clients who needed help to make decisions.

- Staff were committed and passionate about their work. They supported each other well. Sickness absence rates were low and the service provided external counselling and support for staff that needed it.
- Staff received regular supervision, annual appraisals, mandatory training and role specific training. There was a thorough role induction process and staff had opportunities to develop special interests. They knew how to raise concerns and some were confident they could do so without recrimination.
- Clients using the service reflected the diverse ethnic and cultural backgrounds found in the local population and the service catered for all of their needs.
- The service had developed good working relationships with other agencies and worked effectively together to support their clients. There were strong links with other local voluntary groups who offered support to clients and their families.
- There were low numbers of complaints but when a person made a complaint, the service investigated it. Staff understood their duties under the duty of candour and if they made mistakes, they were open about these with clients.

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

- Staff morale was low and staff turnover had been high in the year leading up to the inspection. Most staff said the team was not a happy one and some felt managers did not listen to them. Several staff said they did not receive debriefs after incidents. The managers' office was located on the second floor of the building and some staff felt the physical and professional distance between them was too great. Managers did not demonstrate that they fully appreciated the extent of low morale.
- The service had not been providing the Care Quality Commission (CQC) with regular notifications. This is a requirement of all providers registered with the CQC.
- The service did not have access to cleaning schedules for the building. They only had a communication book between themselves and the contract cleaning company. This meant staff could not easily monitor cleaning carried out on the premises and the kitchen area in particular looked grubby and not well cleaned. The client fridge was dirty and excessively frosted and there were stains on the wall and around the bin.
- The service stored clinical waste bins on a carpeted floor. This meant there was an increased risk to the spread of infection.
- The service could not evidence that medical equipment had been regularly calibrated. This meant there was a risk that equipment such could give inaccurate readings.
- There was no blind or other covering to the window of the needle exchange room. Other clients used the area and could easily see in. This meant there was a risk to the privacy and dignity of clients using this room, particularly if they wanted to show staff their injecting sites.
- The door to the main staff office on the ground floor was routinely left open. Staff said clients sometimes walked into the office, and some had been angry or upset. This meant staff could potentially be at risk of violence or aggression from clients.
- The service had their last Fire Risk Assessment in March 2015. Seven low / medium risk issues were identified as requiring attention, either within three months or by March 2016. Managers did not provide evidence that they had rectified these actions in line with the report recommendations.
- The service did not assess for potential ligature risks in unsupervised areas of the building such as toilets. Managers had not included any ligatures risks in their environmental risk assessment.

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Background to Addaction - Rugby

Addaction is one of the UK's largest specialist treatment charities for drug, alcohol and mental health issues. They have 120 individual contracts across the UK, 63 of which are in England. Addaction Rugby provides one such individual contract. As part of the local commissioning agreement, the service operates under the name The Recovery Partnership. The service is closely linked with four other Addaction services in the Coventry and Warwickshire area, all of whom operate as The Recovery Partnership. The service in Warwickshire is commissioned and funded by the local authority.

Addaction Rugby shares a registered manager with the three other Addaction services in Warwickshire. The Coventry and Warwickshire Addaction services share senior clinicians, senior managers and specialist roles such as data officer, hepatitis C worker, engagement worker and housing worker.

Addaction Rugby provides a community substance misuse service to adults who have drug and alcohol related problems. They provide one to one interventions and group work, treatment and support including detox, a needle exchange and a substitute prescribing service. They provide harm reduction information, issue the emergency opioid overdose medication kits Naloxone and administer hepatitis vaccinations. Staff also provide training and learning opportunities for other organisations working with clients who have substance misuse issues. Figures for June 2016 indicate the service was supporting 230 clients in total.

Addaction Rugby offers a service from 9am – 5pm Monday to Friday. They have extended opening hours to 7pm each Wednesday. The building is situated in the centre of the town and is easily accessed by public transport. There is a small green area to the front, a free car park to the rear and a large municipal park within a few minutes walk of the building. Staff will carry out home visits if this is deemed best for the client and can make home visits if there are children in the household. The service uses recovery champions who are ex-clients and volunteers to facilitate mutual aid partnership meetings, peer support and group sessions. Volunteer roles are designed to fit the needs of the volunteer and the service, so a volunteer may help with administration if this works best for both parties.

Addaction Rugby provides a service to the town of Rugby and the surrounding rural areas. Some people refer themselves to Addaction, some are referred by other organisations such as their GP or social services and others are required to use the service as part of a court order.

The service is registered with the Care Quality Commission to provide:

1. Diagnostic and screening procedures
2. Treatment of disease, disorder or injury

The service was last inspected in September 2013 when they were found to be compliant in all of the areas inspected.

Our inspection team

The team that inspected the service comprised CQC inspector Claire Harper, one other CQC inspector, a specialist advisor who was a substance misuse doctor and an expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using, substance misuse services.

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 Addaction Rugby and asked other organisations for information.

During the inspection visit, the inspection team:

- visited the location, looked at the quality of the physical environment, and observed how staff were supporting and interacting with clients
- spoke with 16 clients
- spoke with the registered manager, the operations manager and the team leader
- spoke with 11 other staff members employed by the service including a doctor, the nurse, administrators and project workers
- spoke with senior regional staff including the clinical lead, the contracts manager, the lead nurse and regional staff undertaking specialist roles such as the hepatitis C co-ordinator, community engagement worker and housing link worker
- spoke with two recovery champions
- observed one doctor led clinic
- observed the waiting room area
- collected feedback using comment cards from eight clients
- looked at eight client care and treatment records, including medicines records
- spoke with commissioners of the service and a local authority safeguarding adults social worker
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We received eight comment cards from clients using the service. Seven were overwhelmingly positive about the service and one was contained mixed feedback.

We also looked at a sample of 37 feedback forms received by the service in June 2016. These had been commissioned specifically to look at what the service was doing well, what it could improve and what it should cease to provide. Of these, 24 were extremely positive about staff and the service, three were negative, four were mixed and eight made suggestions of how to improve the service.

We spoke with 16 clients during the inspection visit, almost all of whom were overwhelmingly positive about the service they received from Addaction.

Summary of this inspection

Clients told us they felt involved as partners in their recovery, staff listened to them and staff were kind and caring toward them. Some clients firmly attributed their improved lives to the support they had received from the service.

However, one client said they felt they had to wait too long to get a prescription after they had missed an appointment, two said there was not enough support to help them deal with their amphetamine usage and one said they had found it difficult sorting out a prescription to go away on holiday.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

We found the following issues that need to improve:

- The service did not routinely inform the Care Quality Commission (CQC) of notifications. This is a requirement of all providers registered with the CQC.
- The service did not have access to cleaning schedules for the building. They only had a communication book between themselves and the contract cleaning company. This meant staff could not easily monitor cleaning carried out on the premises and the kitchen area in particular, looked grubby and not well cleaned.
- The service stored clinical waste bins on a carpeted floor. This meant any spillages could not be effectively cleaned up which could lead to an increased risk in the spread of infection.
- The service could not evidence that medical equipment had been regularly calibrated. This meant there was a risk that equipment such could give inaccurate readings.
- The door to the main staff office on the ground floor was routinely left open. Staff said clients sometimes walked into the office, and some had been angry or upset. This meant there was the potential staff could be at risk of violence or aggression from clients.
- The Fire Risk Assessment was last carried out in March 2015 and seven low / medium risk issues were identified as requiring attention, either within three months or by March 2016. Managers did not provide evidence that these actions had been rectified in line with the report recommendations.
- Following incidents, managers did not routinely provide debrief support to staff.
- The service did not consider ligature risks as part of their environmental risk assessment.

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

- Staff began the risk assessment process as soon as they met with clients. They developed risk management plans when they felt these were required.
- Staff routinely updated client risk assessments.
- Staff were able to identify when there may be safeguarding concerns for adults and children and they knew how to report these to the local authority.

Summary of this inspection

- The service had a robust policy for re-engaging with clients who had missed their appointments.
- Staff knew how to report incidents and routinely did so.
- Mandatory training compliance rates were high.
- The clinic room was well stocked and was visibly clean and well ordered. Medicines were locked in suitable cupboards and the fridge temperature was regularly checked and recorded. The nurse carried out daily clinic room checks.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients were assessed and treated in a timely manner. There were no long waiting lists. Clients received a holistic assessment which looked at all of their needs.
- The service managed transitions for clients well.
- Medical staff carried out a physical examination and communicated with clients' GPs before prescribing.
- Staff understood mental capacity and how to support clients who needed help to make decisions.
- Client records were stored effectively and staff could access them in a timely manner.
- The service had effective multi-disciplinary working arrangements within the team.
- There was a thorough role induction process and staff had opportunities to develop special interests.
- The service had developed good working relationships with other agencies and worked effectively together to support their clients. There were strong links with other local voluntary groups who offered support to clients and their families.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients who used the service were very positive about staff.
- Some clients linked their reduction in substance misuse to the support staff had provided.
- Clients felt staff listened to them and treated them as partners in their recovery.
- Clients described staff as caring, attentive, supportive and good listeners.
- The service routinely gathered feedback from clients and looked at ways they could change things as a result of client suggestions.

Summary of this inspection

- Staff routinely referred clients for other forms of support when they needed it.
- Clients were involved as full partners in their care and staff supported them to reach their recovery goals.
- Staff were passionate about supporting their clients and demonstrated this.

However, we found issues that the service provider could improve:

- There was no blind or covering to the window of the needle exchange room. This meant there was a risk to the privacy and dignity of clients using this room, particularly if they wanted to show staff their injecting sites.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The service operated clinics in the morning, in the afternoon and in the evening to reach as many people as possible.
- The service operated a "drop-in" system so clients could be seen without an appointment.
- Staff rarely cancelled appointments and did not keep clients waiting lengthy periods to be seen.
- Staff actively sought feedback from clients and looked at ways they could improve the ways they did things.
- Staff met with clients to hand out prescriptions, this meant they had regular contact to provide advice and support.
- Levels of complaints were low but when a client made a complaint it was investigated. Clients knew how to make complaints and were confident these would be investigated effectively.
- The service provided information in a variety of formats and languages.
- The service had developed good links with other agencies who could offer additional support to clients.
- Staff knew how to raise concerns but not all were confident they could do so without recrimination.

Are services well-led?

We do not rate standalone substance misuse services.

We found the following areas of good practice:

- Staff were provided with regular supervision and annual appraisals.

Summary of this inspection

- The service used a caseload management tool to support staff and managers with supervision and to ensure clients received regular reviews of their needs.
- The service provided staff with access to an employee support scheme.
- Staff could access a wide variety of training.
- The service supported managers and team leaders to achieve recognised management qualifications.
- The service carried out regular audits including medicines management and audits of case records.
- The service had the support of the wider Addaction organisation so had a robust governance structure to support staff, managers and clients.
- Policies and procedures were regularly reviewed and updated.
- The service regularly looked at ways it could improve the way it did things.

However, we also found areas that the service provider could improve:

- Staff morale was low and staff turnover had been high in the year leading up to the inspection. Most staff said the team was not a happy one.
- Some staff felt managers did not listen to them.
- Several staff said they did not receive debriefs after incidents.
- The managers' office was located on the second floor of the building and some staff felt the physical and professional distance between them was too great.
- Managers did not demonstrate that they fully appreciated the extent of poor staff morale.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Clients using the service did so out of choice, unless they were required to attend as part of a court order. In line with the spirit of the Mental Capacity Act 2005, staff made a presumption of capacity. This means they assumed their clients had the mental capacity to make their own decisions.

At the time of the inspection, staff had not undertaken any specialist training in the Mental Capacity Act. Addaction had developed an e-learning course which they planned to make available to staff within a few weeks of the inspection.

Some staff were not familiar with the term 'mental capacity' or the 2005 Act. However, all staff demonstrated an understanding of situations when a client may lack capacity, for example if they were heavily under the influence of substances. They understood that some clients, such as those with mental health problems or learning disabilities, might require extra support to make some decisions. Staff could give examples of when they had sought support from other professionals within the NHS or social services when they believed their client might benefit from a full assessment of their capacity.

There were no clients using the service who were subject to a community Deprivation of Liberty Safeguards (DoLS) and the service was not required to make any DoLS applications.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

- The service had a door entry system to allow access into the building. Staff in the ground floor office opened either the front or rear door of the building to allow people entry. There was a "signing in" book by the front door which staff routinely asked clients to complete. Clients, who wanted to remain anonymous, could sign in using just their initials. The service also used volunteers and recovery champions to greet clients and settle them in to the waiting room. The back door had a latch on it which staff said clients sometimes set to the open position if they wanted to go out for a cigarette and let themselves back in without pressing the buzzer. Staff said they monitored this to ensure the door remained locked.
- The door to the main staff office on the ground floor was routinely left open. There was a notice advising clients this was a "staff only" area but staff said clients sometimes walked into the office, and some had been angry or upset. This meant there was the potential staff could be at risk of violence or aggression from clients. Some staff, such as administrators had not had training for managing conflict. There was no panic button in this office, but there were telephones staff could use if there was an emergency situation. Additionally, staff kept their personal belongings in the office. However, staff said the office was never left unattended and we observed staff were present in the room at all times during the inspection. The service was in the process of having this door replaced with a stable door. This would afford some protection for staff from potentially aggressive clients but would maintain an "open door" feel to the building which managers wanted to retain. The manager also confirmed they were in the process of installing a panic button in the office for staff to use in an emergency and this would be installed within around six weeks after the inspection.
- Rooms where staff saw clients for individual consultations or group work had panic buttons installed. We checked these and they were working effectively. However, two staff did not know these were panic alarms and had not been instructed in their use. This meant not all staff were clear on how to maintain a safe working environment.
- The service had a lone working policy and staff understood the policy and knew where to find it. If risk management plans deemed it necessary, staff arranged to see clients away from the premises at the police station. However, several staff told us of an incident when the manager had decided staff should see a client on the premises, despite the risk management plan stating otherwise. Staff told us they had been anxious about seeing this client on the premises because they knew them and knew the risk management plan advised them against doing so. However, they felt compelled to do what the manager instructed.
- The clinic room was visibly clean, well ordered and clutter free. The cleaning contractors were responsible for carrying out routine cleaning tasks but the nurse carried out their own checks and cleaning schedule. The fridge in the clinic room was locked and the keys stored securely in a coded access key safe in a ground floor office. Staff checked and recorded the fridge temperature daily. All stock such as vaccines, urine-testing kits and oral swabs were in date. Emergency drugs such as naloxone and adrenaline were kept in a locked cupboard and were in date. Policies and procedures for these were available for staff to refer to and these were up to date. The clinic room was equipped with an examination couch, with an ample

supply of disposable covering, and equipment to measure height, weight and blood pressure. Electrical equipment showed up to date testing stickers. There were hand washing facilities and the room was spacious with good ventilation.

- The service could not evidence that medical equipment had been regularly calibrated since 2013. This meant there was a risk that equipment such could give inaccurate readings. Some medication used for detox can lower blood pressure so it is important that the
- Clients used the downstairs disabled toilet to provide their urine samples for testing. Staff used disposable gloves to handle samples. Samples were then placed in clinical waste bins once the test results had been gathered.
- The service stored clinical waste bins on a carpeted floor. If there were spillages, it would be difficult to thoroughly clean the carpeted area. This meant there was an increased risk to the spread of infection. We advised the manager of this risk and they told us they had not had any incidents of clinical waste falling to the floor but accepted the risk and said they would arrange for the clinical waste bins to be sited on more appropriate flooring as soon as possible.
- Spillage kits were available to clean up spillages if required. The service had an effective clinical waste collection and disposal contract with an external agency.
- The service did not have access to cleaning schedules for the building. They had only a communication book between themselves and the contract cleaning company. This meant staff could not easily monitor cleaning carried out on the premises. The kitchen area was visibly grubby and not well cleaned. There were stains on the wall near the bin. There were two fridges, one labelled “staff” and one labelled “group room”. The staff fridge was clean and well ordered. The group room fridge was visibly dirty and the freezer compartment excessively frosted. It appeared to be in need of thorough cleaning and defrosting to ensure it was clean and working effectively. Inspectors pointed this out to the manager who had not been aware of the issue. There was an unlocked cupboard in the kitchen containing cleaning fluids, screws, metal brackets and various building repair items. These items could pose a risk to staff and clients. We advised the manager who later locked the cupboard.
- Guidance posters for safe handwashing were displayed in all toilets. Some wall mounted hand gel dispensers were empty but the nurse had conveniently placed bottles of hand gel around the building which we saw staff using. Disposable gloves were available for staff who handled client urine sample containers.
- The needle exchange room was small but well stocked and the supplies were in date. Clients could choose from a selection of harm reduction items such as sterile water ampules, syringes, needles and personal sharps containers. They could safely dispose of used needles. Sharps bins were not overfilled and were effectively sealed. Clients could also take a supply of condoms if required.
- Paperwork detailing orders and delivery notes was not up to date but the manager was able to find more current paperwork elsewhere in the building. A change in staff had meant the file in the needle exchange had not been kept up to date in the months leading up to the inspection. The needle exchange room was on the ground floor of the building. Despite its small size, it could be accessed by people using a wheelchair but they would not be able to turn a wheelchair in there. The door contained a glass panel which allowed anyone outside in the corridor, or walking past to use the therapy room, to see into the needle exchange. This potentially compromised the privacy and dignity of clients using the needle exchange.
- The service had up to date servicing agreements for central heating equipment and fresh water testing.
- The service had previously identified a fire warden but the worker had left. There was some confusion over whether or not a new fire warden had been identified. The manager said they were planning to identify a new worker for the role but one worker told us they had recently been appointed although had not received any specific training for the role. Fire safety posters were placed around the building but these referred to a different organisation which was no longer working alongside Addaction in The Recovery Partnership. Managers provided a copy of the most recent Fire Risk

Assessment which was carried out in March 2015. The assessment indicated it should be done annually. It also identified seven low / medium risk issues that required attention, either within three months of the assessment or by March 2016. Managers did not provide evidence that these actions had been rectified in line with the report recommendations. This meant there was the potential that people using the building might not be fully protected against fire risks.

- The service did not consider ligature risks as part of the environmental health and safety assessment. There were ligature risks present in unsupervised areas such as toilets. However, there had been no incidents of any client having ever ligatured in the building and clients had access to many ways in which they could harm themselves because they lived independently in the community. Managers noted if they were made aware of any specific self-harm risk posed by a client, this would be incorporated into their risk management plan and staff would then put measures in place to mitigate the risk.

Safe staffing

- The service was staffed by a full time operations manager and team leader, nine project workers, three administrators, two sessional doctors and a part time nurse. The service location manager also covered three other Warwickshire Addaction services and visited the Rugby site around once a month. Other senior managers, such as the contracts manager, lead nurse and clinical director operated out of the Coventry service and occasionally visited the Addaction Rugby site. The nurse worked 3.5 days at Rugby, and part time at other sites. At the time of the inspection, there were no project worker vacancies; three staff had recently been appointed. There was one advertised vacancy for an administrator and another had recently notified of her intention to leave. Two sessional doctors provided three, two hour clinics each week. Addaction also employed specialist workers who covered all of the Coventry and Warwickshire sites, including a hepatitis C co-ordinator, a data officer, a community engagement officer and a housing link worker. All of these staff provided expertise and support to the Addaction Rugby team.
- Average caseloads for project workers had stood at around 30 in the six months leading up to the inspection. When we visited, most experienced project workers had caseloads in excess of 40. Staff told us their caseloads were manageable. Staff reported there were enough of them to do their jobs but it was a busy service, and could be stretched when there were staff vacancies.
- Data provided by the service showed staff sickness was 8% and turnover was high at 19%, as of April 2016. Leavers included one administrator and four project workers; one of whom had been dismissed. One project worker was soon to transfer to another Addaction service elsewhere and an administrator was working their notice. Inspectors routinely ask staff if their team is a happy one. Out of the 10 staff asked this question, 80% said the team was not a happy one. One site based manager identified that morale was an issue within the team and said they were taking measures to deal with it. Four staff said they were either actively looking for another job or would leave if there were opportunities elsewhere.
- The service rarely used agency staff but had done so within the last year to cover for staff vacancies. One agency worker had successfully since applied for a permanent role in the team.
- Two recovery champions worked at the service, supporting clients with their recovery. There were also two volunteers supporting the service.
- All staff, including recovery champions and volunteers, had a thorough induction to the service. The full induction programme took place over ten weeks and included role specific shadowing. The induction included specialist substance misuse learning, safeguarding and information governance.
- The service had mandatory training modules in equality and diversity, infection prevention and control, safeguarding adults and children and safeguarding information.
- Managers ensured all staff had current Disclosure and Barring Service checks before they were employed to work in the service. Managers also ensured they followed up staff references pending offers of employment. We saw managers did this effectively, refusing to employ staff for whom they could not obtain a satisfactory reference.

Substance misuse services

Assessing and managing risk to clients and staff

- Staff began identifying risks at the initial point of contact with a client, during the first meeting. Staff then completed a full risk assessment at the first full assessment appointment.
- We looked closely at eight client files and found that all contained an initial and a full risk assessment. Some files contained a risk management plan if the risks identified this was required. All but one file showed staff had regularly updated risks. Staff updated risk assessments on a three monthly basis and also in light of significant client events. Managers and staff used a case management tool which had a "red, amber, green" dashboard to help them identify when risk management plans were due to be updated. Staff and managers told us they found this tool helpful. Files indicated that staff were open and transparent with clients about the risks they identified and included these in the client recovery plan.
- The risk assessment included a plan for dealing with the possibility a client may disengage from the service, either temporarily or permanently. The re-engagement plan detailed how staff would try to re-establish the relationship with the client and with whom they could make contact should they be unable to get in touch with the client.
- Some staff, including the nurse, carried out home visits to clients. Addaction had a lone working policy to cover this, which staff used. Staff carried out individual client risk assessments before a home visit. Details of where staff were going and their anticipated return time were recorded in the office.
- The service did not provide specific facilities for clients with children within the building. Staff discouraged clients bringing children to the premises because of the nature of the work undertaken there. Staff could undertake home visits if required. If a client had to bring a child with them, staff would try to arrange a quiet room for them to use rather than the busy waiting room. Another Addaction site was carrying out a trial of visiting all clients who had children residing with them or who had close contact with children. Depending upon the evaluation, this might be rolled out to all Addaction sites in the area.
- There was a clear policy on assessing risks where clients had children or frequent contact with children and vulnerable people. This included the issue of free safe storage boxes to store medicines at home. Safe storage boxes were well advertised throughout the service and workers engaged with clients to encourage them to acknowledge and accept the risks.
- The local authority and had recently set up a multi-agency safeguarding hub (MASH) for safeguarding children and were in the process of setting up one for adults. A MASH co-ordinates safeguarding concerns and provides information and support to other agencies. They collate information from partner agencies to ensure taff were aware of the local MASH arrangements and reflected positively upon its introduction. Staff had experience of referring safeguarding concerns to the local authority and of joint working safeguarding cases. We spoke with a local authority safeguarding adults social worker who spoke positively of the joint working experience with several staff at Addaction Rugby. Safeguarding was a standing agenda item in team meetings and in staff supervision. Managers collated safeguarding information for inclusion on the local "dashboard" which was shared with regional managers and national office.
- The service managed and stored prescriptions safely and securely. They had a specialised administrative role to prepare and manage prescriptions. However, the role was being extended to include general administrative tasks and the worker had been moved from a quiet office to the busy ground floor office where they were required to answer the general phone line and answer the door to clients and visitors. This meant there was the potential the noisy environment and the increase in responsibility could lead the worker to make errors.
- The service had a clear policy for staff and clients to follow if a client lost their prescription, which involved the client reporting this to the police and obtaining a crime number. Clients were required to collect their prescription from staff during normal service hours. Staff reviewed and supported clients during this interaction. The service had introduced this procedure relatively recently and managers reported a significant drop in the rate of missed appointments since implementation.

- Project workers, managers and prescribers were trained in the supply and administration of Naloxone, the emergency opiate overdose antidote.

Track record on safety

- The service had recorded five deaths of clients using the service in the 12 months leading up to the inspection. They evidenced communications between the police, GPs and the coroner. All incidents were recorded on their electronic incident reporting database and they had informed the national Addaction office. However, the service had not routinely informed the Care Quality Commission (CQC) of notifications. This is a regulatory requirement for all providers registered with the CQC.

Reporting incidents and learning from when things go wrong

- All staff were aware of the types of things to record as incidents, such as prescribing errors, violence and aggression and service user health emergencies or deaths. Staff also recorded dispensing errors, even though they were not responsible for these.
- The service used an electronic database to record incidents. All staff knew how to record incidents and all had access to the system to record them.
- All incidents and complaints were analysed locally and also reviewed monthly at Addaction's national critical incident review group (CIRG). Staff reported being advised of lessons learned in monthly team meetings, in newsletters and in supervision. Staff also discussed the learning from incidents in their monthly peer supervision session.
- Addaction had introduced a service wide learning opportunity in relation to incidents. This meant staff could learn from incidents that had occurred elsewhere in the organisation. They did this using anonymised case studies. Staff and managers said they found this a useful learning opportunity.
- Staff gave mixed responses about receiving debriefs after incidents. Three staff said they did not routinely receive a debriefing. The service provided an employee support scheme for any staff who felt they would benefit from it. This included staff involved in incidents. Staff were aware of the scheme and some had successfully used it.

Duty of candour

- The service was open with clients and with commissioners when incidents occurred. Staff understood the need for open and transparent discussions with clients if something went wrong.

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

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

- We looked at eight client case records. All showed clients had a thorough assessment of their needs and had been offered physical health checks including blood borne virus tests.
- All records had recovery plans, which detailed how the service would support the client to reach their goals. Recovery plans were goal oriented and considered client protective factors and strengths such as family support. Staff recorded a history of the clients' substance misuse. Clients had clearly been involved in developing their recovery plans but they were not routine given a copy. In line with National Institute for Health and Care Excellence (NICE) guidelines, as part of the assessment process, staff considered if the client had contact with or had caring responsibilities for children.
- A nominated member of staff attended the local rehabilitation panel to consider clients for an inpatient rehabilitation service. Addaction staff completed the assessment and presented the information to the panel which was chaired by the commissioners. If the client had to wait for an inpatient rehabilitation vacancy or if they were unsuccessful in their bid, Addaction staff continued to provide support in the community.
- The nurse supervised and supported clients with community detox programmes. Addaction had a clear policy for this. The client received a full assessment which included considering avenues of support available to them whilst at home and education for anyone they lived with.

Best practice in treatment and care

- Doctors, and the independent prescriber, followed National Institute for Health and Care Excellence (NICE) guidance including "Methadone and buprenorphine for the management of opioid dependence" 2007. They also followed the Drug Misuse and Dependence: UK guidelines on Clinical Management.
- Clients could access one to one support, group work and peer support. Groups included a women's group, mindfulness and mutual aid participation (MAP) groups. MAP groups are recommended by NICE because they are known to increase successful recovery outcomes for clients.
- Staff could refer clients to an NHS Improving Access to Psychological Therapies programme (IAPT) if required.
- Staff routinely considered physical health needs for clients. The nurse carried out regular health checks. The service referred clients to their GP for electrocardiograms (ECGs) if these were required.
- Staff offered clients blood borne virus testing for hepatitis and HIV which was in line with national best practice and NICE guidelines.
- In line with NICE guidelines, the service offered clients hepatitis vaccinations.
- The service stored only the emergency drugs naloxone and adrenaline and hepatitis vaccinations in the building. These were stored safely and effectively. The training matrix showed most staff were trained to administer naloxone.
- Staff completed the treatment outcome profile (TOP).They then reported TOP to the National Drug Treatment Monitoring System (NDTMS). TOP reports on clients' progress though structured drug treatment. This information is then collated by area and reported by NDTMS on a national website. Staff measured TOP when clients began treatment and every three months thereafter until discharge from the service.
- Staff stored prescriptions in locked rooms. The service had a trained prescription administrator and project worker who prepared and printed prescriptions for doctors to sign. They kept a record of when prescriptions were collected and had a procedure for any prescription that was reported stolen or lost by a client.
- Staff had been involved in local audits for medicines management, and community detox.

Skilled staff to deliver care

- The Addaction Rugby service had a manager, team leader, project workers, nurse, administrators and doctors. Senior managers were shared with the other local Addaction services. Project workers were allocated to individual clients and the nurse and doctor saw them for routine appointments and when there was a specific need. The nurse was a non-medical prescriber which meant they could manage routine prescribing. The nurse and doctors ran clinics each week.
- Addaction had a comprehensive induction for new employees. There was a 10-week induction course, which volunteers and recovery champions also attended. Induction covered safeguarding, drug and alcohol awareness, mutual aid partnership training, harm reduction, information governance, confidentiality and recovery. New staff also had shadowing opportunities to learn from more experienced staff.
- Staff completed both mandatory and specialist training to develop their knowledge and skills. All staff had successfully completed mandatory training in equality and diversity, health and safety, safeguarding adults and children, infection prevention and control and safeguarding information. Project workers also did training in motivational interviewing and cognitive behavioural approaches as standard. All longstanding staff had completed these. The three newer project workers had not yet done so. Two of the three new project workers had yet to complete naloxone training but all others had, even though the training matrix supplied by the service stated they were not required to do this training. There were good opportunities for staff to access training both locally and with the wider Addaction organisation.
- Managers and team leaders were supported to achieve management qualifications.
- Doctors had completed the Royal College of General Practitioners' Certificate in the Management of Drug Misuse.
- In line with the Addaction supervision policy, staff received regular monthly supervision, which managers clearly recorded in their personnel files. Managers used

the case management tool to support the supervision process. This highlighted such things as when client risk assessments and recovery plans required updating, when the client had last had a health check and the last date the worker had seen the client. Both staff and managers felt this was a supportive and useful tool. One member of staff said they felt supervision was target driven but most staff felt it was a useful process.

- Staff routinely received an annual appraisal. These were clear documents which listed measurable goals and action points.
- In line with the Addaction policy, managers could access support from the human resources department and from their own managers when they had to deal with staff sickness absence or performance issues. We saw these issues were dealt with locally in supervision before being escalated. One member of staff had been dismissed from the service in the 12 months leading up to the inspection.

Multidisciplinary and inter-agency team work

- The multidisciplinary team worked effectively together. Staff supported each other with complex case issues and when colleagues were on leave. Even though doctors were employed on a sessional basis, they made themselves available to staff for telephone and face-to-face discussions. They frequently provided support and guidance to staff when complex client issues arose.
- The service held monthly multidisciplinary team meetings (MDTs). The medical director, manager, team leader and project workers attended these meetings. Doctors did not routinely attend but did read the minutes. Staff recorded MDT decisions using the client database. This meant all staff could read what the MDT had agreed, even if they had not been able to attend the meeting.
- The service worked closely with their local NHS community mental health team (CMHT) to develop joint working opportunities for staff to support clients with a dual diagnosis. Dual diagnosis is the term used for clients who have a diagnosed mental health problem and misuse drugs and/or alcohol. Staff both provided and attended training with the CMHT to mutually inform and support each other with the aim of providing improved services to their clients. Staff said they found these opportunities useful and reported good relationships with their local CMHT.
- Staff worked well with agencies such as probation and social care. They attended joint meetings when this was required. Staff reported good working relationships with their colleagues in other agencies even though, at times, they had to work hard to understand each other's role and remit.
- Staff knew which local agencies could offer additional support to their clients and made referrals when necessary. They had close links with a local homeless support charity and a local allotment project. Produce from the allotment was available for clients to take freely from the waiting room.
- The service had access to a recently appointed housing link worker who would support staff to assist clients needing access to housing related support.
- Staff helped out at the local foodbank and enabled clients to access it when they needed to.
- The service worked with the local NSPCC to develop training in safeguarding children and young people. It had identified lead roles for staff in safeguarding.
- The service had a nominated lead member of staff for the multi-agency risk assessment conference (MARAC) who attended the regular MARAC meeting. Staff displayed information on domestic abuse in the waiting room and signposted clients to specialist support.
- The service worked well with the local mutual aid partnership which held a regular drop-in session at the service. Referral rates for support were high.

Good practice in applying the MCA

- Clients using the service did so out of choice, unless they were required to attend as part of a court order. In line with the spirit of the Mental Capacity Act 2005, staff made a presumption of capacity. This means they assumed their clients had the mental capacity to make their own decisions. In all the client records we inspected, staff had discussed consent to treatment. There were signed copies of the consent to treatment form in each file. Almost all records showed this was regularly discussed with clients at three monthly

intervals. The consent document also detailed with whom the client was willing for staff to discuss their needs. This was particularly important because the form also documented the client re-engagement plan which detailed who they could contact should the client miss any appointments.

- At the time of the inspection, staff had not undertaken any specialist training in the Mental Capacity Act 2005. Addaction had developed an e-learning course which they planned to make available to staff within a few weeks of the inspection.
- Some staff were not familiar with the term mental capacity or the 2005 Act. However, all staff demonstrated an understanding of situations when a client may lack capacity, for example if they were heavily under the influence of substances. Staff were able to explain what they would do if a client presented to the service in a way which rendered them temporarily unable to make safe decisions. They understood that some clients, such as those with mental health problems or learning disabilities, might require extra support to make some decisions. Staff could give examples of when they had sought support from other professionals within the NHS or social services when they believed their client might benefit from a full assessment of their capacity.
- There were no clients using the service who were subject to a community Deprivation of Liberty Safeguards (DoLS) application and the service was not required to make any DoLS applications.

Equality and human rights

- The service worked within the Equality Act 2010. All staff received training in equality and diversity as a mandatory item.
- The service was accessible to people from all communities. It worked in partnership with the local Community Safety Partnership to increase awareness of substance misuse and reduce the stigma attached to seeking support for people from Eastern European and black and minority ethnic communities.
- The service had developed a good relationship with their local community mental health team (CMHT). They had developed a joint training programme with the CMHT which mutually enhanced the skills and knowledge of staff in each service.
- The service did not discriminate against anyone who may need their support. The waiting room contained useful information for local support groups including lesbian, gay, bisexual and transgender people, older people, people at risk of domestic abuse and young people at risk of sexual exploitation.
- The service supported people with disabilities and specialist needs, including pregnant women.

Management of transition arrangements, referral and discharge

- Staff managed transition arrangements well. They had good links with their local community mental health team, the probation service and the police. The service had link workers for example: criminal justice, mental health and safeguarding, which enabled good communication and eased transitions. A worker from the probation service had recently begun seeing their clients at the Addaction Rugby building.
- The service worked well with the local mutual aid partnership who held a regular drop-in session at the service. Referral rates for support were high.
- Staff prioritised the arrangements to support prisoners being released from prison who needed substitute prescribing. They were assessed quickly and treatment plans put in place with substitute prescribing arrangements aimed to reduce the likelihood them resuming substance misuse.
- The service had an open and transparent re-engagement policy so clients knew what would happen if they missed appointments or if they ever needed to use the service again in the future.
- Discharge was discussed from the outset when staff supported clients to develop their recovery plans.
- The service worked with a local youth substance misuse service, in order to support 18 year olds to transition into adult substance misuse services.
- Clients who were referred by other organisations said the transition was smooth and successful.

Substance misuse services

Are substance misuse services caring?

Kindness, dignity, respect and support

- All the clients we spoke with and received comments from were highly positive about the support they received from staff. A number of clients specifically named staff who they felt were particularly caring and supportive to them.
- Apart from an uncovered window in the needle exchange, clients' privacy and dignity was maintained in the building. Clients told us staff treated them with dignity and respect and were caring in their attitude toward people using the service.
- We observed staff interacting with clients in the building and on the telephone. They demonstrated, kindness, patience and seemed to genuinely care about their client's recovery. Staff demonstrated they knew their clients well, understanding what helped and would did not help them on their recovery journey.
- A number of clients told us they felt staff treated them well and did not judge them, which they really valued.

The involvement of clients in the care they receive

- Clients told us they were fully engaged in their recovery plans and understood the care and treatment they were receiving. Within the parameters available, clients were given choice in their treatment.
- Staff did not routinely give clients a copy of their recovery plan. They said clients did not usually want a copy. Clients confirmed to us they did not want a copy of the document. It was clear from the people we spoke with, they knew what their recovery plan was. They had been fully involved in developing it so did not feel they needed a paper copy.
- The recovery plans were not detailed documents but they did contain the essential information needed to engage a client with their recovery programme.
- The service provided a lot of useful information in different formats such as DVDs, leaflets and helplines.
- There was a local advocacy service available if clients needed to use it but those we spoke with felt able to advocate for themselves and said staff supported them whenever they needed it.
- The service had a comments and suggestions box in the waiting room. During the inspection visit, we also saw staff politely asking clients if they would take part in a short survey about the service. Clients were offered a free ticket in a prize raffle if they took part and we saw this encouraged a number of people. Staff helped those clients who needed it, by filling out the survey for them if they wanted to.
- The service had recently contracted another organisation to collect and analyse client feedback. The survey asked what Addaction did well, what they better and what else could do could they be doing. The manager showed us a sample of 37 replies. The responses were overwhelmingly positive with only four negative comments, one mixed and 24 positive. Eight replies gave suggestions of other things the service could do to support them. Several comments noted how helpful the service had been to families and carers, many said how great they found staff and a large number showed gratitude for the help and support staff had given them. The manager was positive about the survey results and was planning to look at how they could implement some changes as a result.

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

Access and discharge

- Referrals for the service came from other organisations such as local voluntary sector groups, the probation service, social services, community mental health teams and GPs. Clients could also refer themselves. Some clients were referred as part of a court order.
- The service accepted referrals for any adult over 18 who wanted support to recover from a drug or alcohol misuse problem. They referred young people under 18 to another local specialist service. The service also supported people who were required to attend as part of a court order and those leaving prison. Staff put in place speedy substitute prescribing arrangements for prisoners about to be released. This was to reduce the likelihood of them using illegal substances and any reoffending behaviour.

- The service did not operate waiting lists. Clients attending the service unannounced would be seen by a duty worker for an initial assessment and then offered an appointment for a full assessment within around 10 days. Clients would then be allocated a project worker for longer term work. The service was piloting the use of two duty workers and if the arrangement proved effective, they would continue. Two duty workers made it easier to see anyone who came to the service on a "drop-in" basis quickly. Duty workers also answered the telephone, providing advice and support to anyone who needed it.
- The service held one two-hour evening clinic a week for clients who were at work during the day. We saw this clinic was well attended and clients were positive about the way it enabled them to attend after they had finished work.
- The service was starting a "structured day" programme the week after the inspection took place. This was an in-depth programme to support clients on their recovery journey. The programme included: understanding substance misuse, harm reduction, alcohol awareness and the self-build programme.
- In line with the National Institute for Heath and Care Excellence (NICE) guidelines the service had a clear re-engagement policy, which clients agreed to from the outset of treatment. Staff used a variety of methods to re-establish contact with clients who had missed appointments which included telephoning them, sending text messages and letters. They kept good contact with dispensing pharmacies and if this was an agreed method with the client, they would leave messages with the pharmacy. Pharmacies commonly advised the service if a client failed to attend for their supervised consumption of methadone. When this happened, clients were aware that their prescription would be suspended until they re-established contact with the service.
- Clients could continue to use the service until they no longer needed it.
- The service had a website, which provided useful information and links for clients, their families and potential clients. However, the website displayed incorrect information about the opening hours. Inspectors pointed this out to the manager who arranged for it to be updated shortly after the inspection. However, despite the changes, the revised opening hours were still incorrect because they failed to show the times of the evening clinic. This meant potential clients might be put off attending if they thought the service was only open during normal office hours.

The facilities promote recovery, comfort, dignity and confidentiality

- The service operated from a Victorian semidetached town house in the centre of Rugby. There was a comfortable waiting room and clients attending group work could have a drink if they wanted. The waiting room was bright and welcoming and contained a large amount of useful information for clients and their families. There were posters advertising other useful local organisations including those for young people and older people. Staff presented the information well and it promoted hope and avenues of support for clients using the service. Staff provided a warm welcome for people coming into the building.
- Recovery champions regularly greeted clients and showed them to the waiting area. They also co-facilitated or led mutual aid groups. Mutual aid participation provided alongside formal support is known to improve recovery success. The local mutual aid partnership ran regular "drop ins" and support for anyone needing it at Addaction Rugby.
- Harm reduction information was available in other languages and in DVD format as well as in leaflets.
- There was a kitchen area with a bistro style table and chairs for staff or clients wishing to sit there. There were facilities to make a free hot drink and there was a fridge for clients attending group work to use. However, the fridge looked unclean and was excessively frosted.
- The clinic room and therapy rooms were comfortably appointed and conversations could not be heard by those outside which promoted the privacy and dignity of clients using them. However, the needle exchange room had a glass panel which was not covered. This meant people using the facility could be seen by anyone passing the room so their dignity and privacy was potentially compromised.

Meeting the needs of all clients

- The service met the needs of a wide range of clients. The majority using the service, 36%, were aged between 30 and 39, and most clients described themselves as white British. Only three percent had a first language other than English but the service had arranged for leaflets to be printed in Polish, the most popular language after English. Two of clients described themselves as having a learning disability. Staff were able to describe how they had previously supported clients with a learning disability by getting support from other organisations.
- Staff knew how to access interpreters when required and the service had translated harm reduction information into Polish. The service worked with the local council to link with a specialist worker to access the local Eastern European community. They were also working with the local Community Safety Partnership to raise awareness of substance misuse, produce literature and reduce stigma in seeking support for local people from Eastern European and Black and Minority Ethnic communities.
- The national Addaction website had a talk aloud function which was available in a number of languages.
- The service provided a women only mutual aid partnership (MAP) group each Friday.
- There were separate male and female toilets on the first floor. However, the female toilets did not display a sign indicating this. Inspectors informed the manager who rectified this immediately.
- The service was accessible by public transport and had a free carpark to the rear and street parking to the front.
- The service could access the "recovery fund" to meet the cost of for example; education, learning, travel passes or leisure items which could help a client with their recovery. We saw innovative examples of this such as gardening equipment and gym passes. The fund provided individual grants of up to £200 and was managed by the locality services manager. To access the fund, Staff completed an application form describing how the item would benefit the client and their recovery.
- The service was accessible to clients with mobility problems. There was a ramp to the rear entrance and a wheelchair friendly ground floor lavatory. The clinic room, waiting room and a meeting room were all accessible to people using wheelchairs. However, the needles exchange room was quite small and would not have accommodated the turning of a wheelchair. The group room was situated on the first floor and managers told us if they ever had a person with restricted mobility, who could not get upstairs to the group room, the service had arrangements with other organisations from whom they could rent a room to hold group meetings. They noted this had not been necessary in the past but demonstrated they had the means of meeting the needs of clients with restricted mobility if required.

Listening to and learning from concerns and complaints

- The Coventry and Warwickshire clinical social governance group (CSGG) reviewed incidents and complaints then collated the information for distribution amongst local Addaction services.
- Managers and staff were eager to gather client feedback and use this to improve the way they did things.
- Clients told us they knew how to make a complaint if they were unhappy with the service. There were low numbers of complaints but when a complaint was made, it was investigated. Staff understood their duties under the duty of candour and if they made mistakes, they were open with clients. They supported clients to resolve complaints informally initially. The service received regular compliments from clients.

Are substance misuse services well-led?

Vision and values

- Addaction's values were to be passionate, determined and professional. Staff understood the organisation's values and demonstrated their commitment to them in their daily engagement with clients. Staff showed a genuine commitment to supporting their clients throughout their recovery journey.
- The service was committed to supporting clients to move forward and if they wanted to, share their experience with others by becoming a recovery champion and perhaps even a volunteer.
- Two members of staff felt the organisation's values did not extend to the treatment of its staff.

Substance misuse services

Good governance

- The service had a robust overarching governance structure set down by the wider Addaction organisation. Policies and procedures were regularly reviewed and updated for the whole organisation in line with national guidelines and advances in clinical practice. The Coventry and Warwickshire Addaction clinical social governance group (CSGG) received updates on these and filtered the information to staff via minutes of the meeting.
- The CSGG reviewed incidents and safeguarding concerns then collated the information for distribution amongst local Addaction services. Information on lessons learned were circulated both locally and nationally throughout Addaction. The CSGG also reported on local audits, medicines management, service user feedback (compliments and complaints), practice developments and training updates. Managers made all of this information available to staff.
- In line with Addaction policy, staff received regular supervision and an annual appraisal, which were well documented. We reviewed a selection of personnel files and found them to be an effective record of support and performance. The service held a training matrix which showed when staff had completed their mandatory training.
- Local managers had control of their financial budgets and recruitment, which meant they had the level of autonomy necessary to run the service.
- The service held a payment by results contract with its commissioners. This meant their performance was measured in terms of key performance indicators (KPIs). The KPIs were linked to the main client groups (alcohol, opiates and non-opiates), and whether clients came back into the service or successfully met their recovery goals. The KPIs linked to national monitoring via treatment outcomes profile (TOP) and were reported to the National Drug Treatment Monitoring System (NDTMS). TOP reports on clients' progress though structured drug treatment. This information is then collated by area and reported by NDTMS on a national website.

Leadership, morale and staff engagement

- Staff could provide feedback about the service at a staff forum, in team meetings and in supervision. Addaction also provided staff with access to an 'ask Simon' system which enabled them to give feedback to the senior management team. Local managers said they felt able to provide feedback about the service and felt they contributed to the development of the service and to the wider Addaction organisation. We asked seven staff if they were able to provide feedback about the service to their leaders. Four said they were. However, one said they were not encouraged to provide feedback, one said they could provide feedback but managers expected them to have their own solutions and another said they could provide feedback but felt managers did not listen to them.
- Local leaders were present in the building. The operations manager and team leader shared an office on the second floor, which some staff felt created a physical and professional barrier, limiting their accessibility.
- Staff said the locality service manager came to the service about once a month but they rarely saw other senior managers. Several staff noted there had been "roadshows" previously when the organisation had been planning significant change.
- Morale amongst staff was very poor. Inspectors routinely ask staff if the team is a happy one. Of the 10 staff we asked, eight told us it was not a happy team to work in. They said Addaction Rugby had, until the last year or so, been a popular and happy place to work. Four staff told us they were either actively looking for jobs elsewhere or they would leave if they found the opportunity. Two staff told us that five or six colleagues had left the team within the last six months and felt this exemplified difficulties in the team. One member of staff said, on the whole, it was a happy team and another said it was generally a happy team but there had been some discontent over recent changes. Not feeling supported to do the job, split dynamics, being expected to have solutions to problems, when in fact they wanted managerial guidance and inconsistent managers were some issues staff referred to when describing their low morale. Overall, at the time of the inspection, staff reported that Addaction Rugby was not a happy team in which to work . When asked the same question, one senior leader who not based on site, said they were

unaware of any difficulties in the team and another said it was a happy team. One of the two local managers said they were aware of poor morale and were taking measures to deal with it. Overall, managers did not demonstrate they had a thorough understanding of the extent and depth of poor morale within the service.

- Most members of staff were aware of the whistleblowing policy and how to report concerns if they needed to. However, three were not sure they could confidently use the process without fear of recrimination. This meant not all staff felt able to confidently report concerns.
- Managers were confident all staff received a debriefing when required. However, three members of staff said they had not received debriefs following incidents.
- There were no reported incidents of harassment or bullying within the service. However, six staff volunteered that there were differences in the way managers treated them. Three of these said managers had “favourites” who they treated preferentially. Staff sited examples such as some colleagues being allowed to start and finish at different times, some having to cover the late clinic and some not, differences in how rigorously managers applied the sickness process, some being allowed to easily take time off in lieu or annual leave while others had to "jump through hoops". Two members of staff said they had observed bullying within the team and had advised a senior manager, but nothing had been done to resolve it.
- Staff and managers noted there were differences in staff terms and conditions as a result of the Transfer of Undertakings Protection of Employment Regulations (TUPE), when staff had transferred from one or even two previous employers responsible for providing substance misuse services in the area. Whilst the TUPE arrangements would account for some differences, staff nonetheless, perceived managers did not treat them equally within the organisation.
- Staff were kept informed of local and national organisational developments by newsletters, emails and in team meetings. The Addaction website also held useful news and information.
- Staff were able to use local and national training events as a means of networking with each other. Staff had access to an array of specialist face-to-face and e-learning substance misuse training which they could access with the approval of their manager. A number of training events were held in other parts of the country and staff said Addaction would also pay for their travel to attend if the course was not held locally. The service supported team leaders to achieve the Institute for Learning and Management (ILM) level 3. ILM is an accepted management qualification.

Commitment to quality improvement and innovation

- Managers and staff were positive about peer audits and looked forward to the plans for teams within the region to audit each other’s service. Several managers and staff had been trained in the national peer audit tool and were available to undertake these across Addaction’s countrywide portfolio of services. The service routinely carried out internal audits looking at all aspects of the service.
- The service was keen to gather feedback from clients and used innovative methods to do so. One example included running a prize raffle for clients who were willing to complete a feedback form. Staff were keen to improve the way they did things based on client feedback.
- The case management tool allowed staff and managers to identify areas of good practice and areas requiring improvement. Areas it supported them with included identifying when clients were last seen, when they had last had a health check and when their risk assessments and recovery plans were due for review.
- The service was keen to provide training to other agencies and professionals working with clients with substance misuse issues. They had recently provided palliative care training and training for the local NHS community mental health team.
- The service worked locally with the Prince’s Trust to provide work and learning opportunities for young people aged 16-25.
- The service worked with the local Community Safety Partnership to raise awareness of substance misuse, produce literature and reduce stigma in seeking support for local people from Eastern European and Black and Minority Ethnic communities.
- Staff had recently undertaking smoking cessation training and would soon offer this additional support to clients.

Substance misuse services

- The service had scheduled level three safeguarding children training for staff. This had previously been accessible only to managers.

Outstanding practice and areas for improvement

Outstanding practice

There was no outstanding practice to note.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that clinical waste bins are sited in an area which can be thoroughly cleaned in the event of spillages.
- The provider must send notifications to the Care Quality Commission as set out in the registration of the service.
- The provider must ensure that medical equipment is calibrated in line with manufacturers' guidelines.

Action the provider SHOULD take to improve

- The provider should ensure it complies with recommendations set out in its Fire Risk Assessment, implementing any actions in a timely manner.
- The provider should ensure it has access to clear cleaning schedules for the building for the purposes of controlling the prevention of infection.
- The provider should ensure all relevant equipment and areas of the building are appropriately cleaned for the purposes of controlling the prevention of infection.
- The provider should ensure it deals effectively with poor staff morale.
- The provider should ensure staff in all offices of the building feel safe and are protected from potentially violent or aggressive clients
- The provider should ensure all staff are confident in the use of panic buttons on the premises.
- The provider should ensure it considers ligature risks in parts of the building where clients have unsupervised access.
- The provider should ensure that any staff designated with specific roles such as Fire Warden receive suitable training and preparation for the role.
- The provider should ensure effective record keeping enabling staff to locate important documents such as evidence of equipment calibration and delivery notes of needle exchange stock.
- The provider should ensure that all staff receive debrief support following incidents.

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 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The provider did not ensure medical equipment was suitably calibrated in line with manufacturers' guidelines. Medical equipment had not been calibrated in line with manufactures' guidelines. This was a breach of Regulation 15 (1) (e)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person did not notify the Care Quality Commission without delay of any abuse or allegation of abuse in relation to a service user or of any incident which was reported to, or investigated by, the police. The service did not notify the Care Quality Commission of incidents, which it was required to do. This was a breach of Regulation 18(2)(e)(f)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The provider did not ensure clinical waste bins were sited in an area which, in the event of spillages, could be thoroughly cleaned to reduce the risk of infection.

Clinical waste bins were sited on a carpeted floor.

This was a breach of Regulation 12 (2) (h)