Addaction - Bradford Clinical Support Services

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

Ratings

Overall rating for this location

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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

We do not currently rate independent standalone substance misuse services.

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

- Staff did not always follow Addaction's procedures for blood borne virus screening and allowed a client to take their own blood in the clinic appointment. Staff did not always consult with the electronic client record before signing prescriptions for controlled drugs, like methadone or buprenorphine. They also compromised the confidentiality, privacy and respect for two of their clients by signing a client's prescription during the appointment of another client. The serial numbers of the prescriptions used and given to clients was not recorded.
- Addaction did not have fully integrated governance at a strategic level with the partner organisations in the Bradford recovery system. Except for the quarterly quality visits completed by senior managers and internal quality auditors that reviewed the governance systems and the service delivery, there was no routine clinical audit schedule in place. The service did not routinely collect and monitor data to use proactively to manage risks associated with prescribing medication, and to support staff to fulfil their role.
- There was no contingency plan to provide staff with documented managerial supervision when the service manager was no longer at the service. The personnel records that we reviewed showed that staff had not received managerial supervision for at least two months prior to inspection. However, there were weekly team meetings and staff told us they could always access supervision if they needed it.

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

- Addaction had sufficient staff to deliver care and treatment. Agency staff were rarely used as the service employed sessional prescribers to cover additional shifts. Staff mandatory training compliance was above 98%. Team meetings that all Addaction staff attended included detailed case discussion about clients and practice with input from all the Addaction team, as well as updates on safeguarding and the new procedures implemented. Staff employed by Addaction demonstrated a good understanding of Addaction's values and guiding principles, and staff knew who the senior managers were. They told us that they felt well supported and staff were able to progress through the organisation.
- The clinical assessments completed by doctors and non-medical prescribers were detailed and included discussions about risk and assessments of the client's physical and mental health, and social circumstances.Staff had a good understanding of child and adult safeguarding procedures. Training, guidance, systems, and a named safeguarding lead, were in place to support staff. All treatment was underpinned by national guidance and staff had a good understanding of the best practice guidance that was appropriate with regard to prescribing and physical health care. Staff followed cold chain procedures with regard to the storage and transport of vaccines to ensure they remained at the correct temperature required to ensure they worked properly. Information was available for clients about treatment and medication, and consent and confidentiality was explained to clients.
- Addaction had late night prescribing clinics available and also had a women's clinic every week. Staff could access language line for clients whose first language was not English and could provide a sign language interpreter for deaf clients. Most of the clients told us that the doctors and nurses were kind, caring and polite. All clients knew how to complain. Complaints were responded to by the service in a timely manner, investigated where appropriate and any identified learning was cascaded to the teams.
- Addaction provided data to the local commissioners on their outcomes and were performing well on these targets. The role of the medical lead focused on building partnerships, reviewing policies and

Summary of findings

procedures to ensure they fitted in with national guidance, and service development. Client feedback and staff feedback was collected to inform service delivery.

Summary of findings

Contents

Location name here

Services we looked at
Substance misuse services

Summary of this inspection

Background to Addaction - Bradford Clinical Support Services

Bradford Clinical Support Services is one of 46 locations registered by the provider Addaction. This location was registered by the provider on the 4 August 2015. The location has a registered manager and a responsible person, and provides the following regulated activities:

• Diagnostic and screening procedures

• Treatment of disease, disorder or injury

Addaction works in partnership with three other organisations to deliver care and treatment in the Bradford Recovery System. They were awarded the contract in July 2015 to deliver the clinical support services for this system.

The clinical support service includes the provision of physical healthcare and well-being services, such as physical health assessments and blood borne virus screening and interventions, as well as the prescribing interventions primarily for opioid dependence.

This clinical provision is delivered by doctors, non-medical prescribers and nurses employed by Addaction across 10 sites, known as host sites.

Addaction Bradford Clinical Support Services has not previously been inspected.

This inspection on the 20 October 2016 is the services first inspection using the new Care Quality Commission inspection methodology, and using the updated Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our inspection team

The team that inspected the service comprised of the lead CQC inspection manager Kate Gorse-Brightmore, two inspectors, and a specialist substance misuse advisor.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location. We received feedback about the service from the local commissioners and Public

Summary of this inspection

Health England. We also received feedback from the three partner organisations that worked with Addaction to deliver care and treatment in the Bradford recovery system.

During the inspection we:

- visited the main hub in the centre of Bradford where Addaction provides the clinical support services as part of the Bradford recovery system
- looked at the quality of the physical environment where clinical care and treatment was delivered at one of the host sites, and observed how staff were caring for clients
- spoke with seven clients
- spoke with the contract manager who was the registered manager
- spoke with nine other staff members including the medical lead, the nurse manager, doctors, non-medical prescribers, specialist nurses, and the administration and data manager
- attended and observed seven clinics, including five prescribing clinics and two health and well-being clinics with the nurse
- collected feedback using comment cards from 31 clients
- looked at 16 care and treatment records for clients
- reviewed four personnel records
- attended a team meeting
- and looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with seven clients during the inspection and received 31 comment cards from clients.

Clients told us that they felt safe when they attended their clinic appointments.

Most clients told us the doctors and nurses were kind, caring and respectful towards them. They told us that staff were generally polite and respectful. However, there were three negative comments from clients regarding the perceived attitude of staff towards them.

Clients told us that appointments were rarely cancelled but that clinics sometimes ran behind schedule. Some clients we spoke with felt it unfair that if they were running late for their appointment, the prescriber may not see them.

Clients told us that they had their treatment options explained to them, and they were involved in decisions about their care. However, not all clients said that they were encouraged by the clinical staff to reduce their medication: one client told us that she had initiated those discussions.

Clients told us that they had not been asked if their family or carers wanted to be involved in the treatment, including attending clinic appointments as support.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

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

- Staff did not always consult with the electronic client record before signing prescriptions for controlled drugs, like methadone or buprenorphine.
- Staff did not always follow Addaction's procedures for blood borne virus screening and allowed a client to take their own blood in the clinic appointment.
- The serial numbers of the prescriptions used and given to clients was not recorded.

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

- Addaction had a system in place to ensure that the clinic rooms were clean and well maintained, with the necessary equipment.
- Addaction had sufficient staff to deliver care and treatment. Agency staff were rarely used as the service employed sessional prescribers to cover additional shifts. Staff mandatory training compliance was above 98%.
- Staff followed cold chain procedures with regard to the storage and transport of vaccines to ensure they remained at the correct temperature required to ensure they worked properly.
- Risk was discussed throughout the clinical consultations with the client by the doctors and nurses in the prescribing clinics and the health and well-being clinics, and recorded in the electronic record.
- Staff had a good understanding of child and adult safeguarding procedures. Training, guidance, systems, and a name safeguarding lead, were in place to support staff.
- All staff knew how to report incidents and could describe what types of occurrences they would report. Feedback from incidents was shared in team meetings.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

Summary of this inspection

- The clinical assessments completed by doctors and non-medical prescribers were detailed and included assessments of the client's physical and mental health and social circumstances.
- All treatment was underpinned by national guidance and staff had a good understanding of the best practice guidance that was appropriate with regard to prescribing and physical health care.
- There were weekly team meetings that all Addaction staff attended. These included detailed case discussion about clients and practice with input from all the Addaction team, as well as updates on safeguarding and the new procedures implemented.
- Addaction doctors and nurses worked closely with the recovery workers in the host services. We reviewed records that demonstrated this partnership approach and three-way appointments.
- Transition between services worked well and clients described the services that they accessed in the Bradford recovery system as one service.
- The service considered equality and human rights in their recruitment procedures, their approach towards their staff, as well as in their work with clients and their service provision.

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

- The personnel records that we reviewed showed that staff had not received managerial supervision for at least two months prior to inspection.

Are services caring?

We do not currently rate standalone substance misuse services.

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

- We had a concern that during a clinic appointment where a prescriber was completing a medical review with a client, a recovery worker entered the appointment at the agreement of the prescriber to have another client's prescription signed. The recovery worker was employed at the host site by one of Addaction's partner organisations in the Bradford recovery system. This compromised the privacy and level of respect shown towards the client in the appointment, and had the potential to breach the other client's confidentiality whose name would have been on the prescription.

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

Summary of this inspection

- Most of the clients told us that the doctors and nurses were kind, caring and polite.
- A 'consent to share information' form was used at all the host sites in the Bradford recovery system at the start of the clients' treatment, this included information sharing with Addaction Bradford clinical support services.
- During our inspection we spoke with people who used the service and they told us that their treatment options were explained to them, and they were involved in decisions about their care.
- Addaction collected weekly client feedback which was fed back to the staff and clients. We observed the feedback outcomes on the wall at the host site we visited during the inspection.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- All clients were seen for a prescribing assessment appointment by Addaction within the locally agreed target of five days between 1 April 2016 and 30 September 2016.
- Clients waited less than three weeks to access treatment interventions. The Bradford recovery system which included Addaction was performing better than the national average for wait times to access treatment.
- We observed information available for clients on medication including methadone and 'Subxone,' which is a type of buprenorphine medication. Both medications are substitute medications used for opiate dependency. There was also a perinatal leaflet that had been developed for clients who wanted to get pregnant or who were pregnant.
- Addaction held one late night prescribing clinic at five host sites. They also held a women's clinic every Thursday evening in one of the central host sites.
- Staff could access language line for clients whose first language was not English and could provide a sign language interpreter for deaf clients. We observed leaflets on treatment available in the different languages spoken by people who use the service.
- All clients knew how to complain. Complaints were responded to by the service in a timely manner, investigated where appropriate and any identified learning was cascaded to the teams.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

Summary of this inspection

- Staff employed by Addaction demonstrated a good understanding of Addaction's values and guiding principles, and staff knew who the senior managers were.
- Addaction provided data to the local commissioners on their outcomes and were performing well on these targets.
- Staff reported that they felt supported, that the team was open to sharing ideas, and that they could raise concerns without fear of victimisation.
- We saw evidence that staff could progress through the service, with Addaction encouraging the specialist nurses to complete the qualification to become non-medical prescribers.
- Between November 2015 and April 2016, senior managers and internal quality auditors who were not located at the service undertook four quality visits. They reviewed the governance systems and the service delivery.
- The role of the medical lead focussed on building partnerships, reviewing policies and procedures to ensure they fitted in with national guidance, and service development.

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

- Addaction did not have a local routine clinical audit schedule, or routinely collect and monitor data to use proactively to manage risks associated with prescribing medication and to support staff to fulfil their role, and.to ensure the safety and quality of the service.
- There was no contingency plan to provide staff with documented managerial supervision when the service manager was no longer at the service. However, there were weekly team meetings and staff told us they could always access supervision if they needed it.
- Addaction did not have fully integrated governance at a strategic level with the partner organisations in the Bradford recovery system to review the safety and quality of the service delivery.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act is a piece of legislation which enables people to make their own decisions wherever possible and provides a process and guidance for decision making where people are unable to make decisions for themselves.

Mental Capacity Act training was mandatory and all staff that were required to complete this training had done so.

The safeguarding adult policy contained information about the Mental Capacity Act, principles of the Act, and demonstrating decision-making capacity, to inform and guide staff. Staff also told us that Addaction had its own mental capacity act policy that could be accessed using the service's intranet.

Most of the staff we spoke to had a good understanding of the Mental Capacity Act including the five statutory principles and also the application of the Act within their role. Information about a client's capacity, and any decisions made, were recorded on the client electronic recording system.

Staff confirmed that if they needed any advice on decisions around capacity they would discuss this with the nurse manager who was the safeguarding lead, or the medical lead.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

Addaction did not own or lease any of the buildings (host sites) that the doctors and nurses delivered care and treatment from. These 10 host sites and the management of the premises were the responsibility of the partner organisations in the Bradford recovery system.

Addaction rented a space in the central hub in Bradford for their local management and administration function and they worked in partnership with all the partner organisations to ensure the clinic environments were clean and safe.

We observed the clinic rooms at the central hub in Bradford to be clean and tidy. The contract manager told us that all the clinic rooms used had been completed and equipped to NHS specifications. Staff completed a checklist at the start of their clinics at the host sites to identify any issues with cleanliness, infection control, and health and safety. The contract manager told us that any issues identified would be escalated to the appropriate person at the host site or in the partner organisation. An example was given where Addaction had requested a deep clean for the clinic environment in line with their own infection control policy. We saw team meetings minutes where cleanliness of clinic rooms was raised and reviewed at the following team meetings, and action taken by the service manager.

Staff we spoke with had a good understanding of infection control principles. Addaction had an infection control policy that included the use of personal protective equipment, hand hygiene, and vaccinations for employees. It also included the procedures to follow for spillages of body fluids, epidemic and pandemic contingencies like influenza and swine flu, managing sharps, disposal of clinical waste, transportation of clinical waste and sharps, and communicable diseases. Addaction had a hand hygiene policy. The contract manager or service manager of the organisation was responsible for ensuring all staff, including locum staff, were aware of these policies. Addaction had completed an infection control audit at each site in May 2016, and the provider completed the identified actions.. The contract manager told us that the outcome from this audit was cascaded to all staff and their partner organisations. All staff had completed the mandatory infection control training.

Addaction staff were orientated to the host sites that they would be working at during their induction period, or when they moved sites. This included the signing in procedure, health and safety checks, fire alarms and fire safety, and the use of panic alarms for emergency situations. Part of the induction also included staff familiarising themselves with Addaction's health and safety policy. All staff had completed the health and safety mandatory training. The clinic rooms we observed were fitted with panic buttons.

The clinic rooms at the central hub in Bradford had both hand washing facilities and access to hand sanitizer. An examination couch, blood pressure monitor and weighing scales were available for use. There were systems in place to ensure that equipment was checked and calibrated.

Vaccines were stored in fridges at each of the host sites. Staff checked fridge temperatures on a daily basis to ensure these were stored at the correct temperature. Staff used supplementary cold storage bags to maintain safe transport of these vaccines to outlying clinics. All clinical waste was disposed of by the partner agencies at the host sites. At the central hub in Bradford, the cold chain system to monitor the fridge temperatures was established and staff completed the required checks. The temperatures were observed to be between 2-8 degrees centigrade as required.

The drug cupboard at the hub was locked with key access via a coded mechanism. Emergency drugs were present and checked and in date. Adrenaline (used if a client had a serious allergic reaction) was available as was naloxone (used in cases of opiate overdose). Staff were trained in first aid and in naloxone recovery rescue across the partnership.

Safe staffing

At the time of the inspection there were 16 staff working for Addaction. This included:

- a medical lead who worked 10.5 hours
- a full time contracts manager who worked in the service up to two and a half days per week
- a full time nurse manager who was also the named safeguarding lead
- a full time project administrator who provided the administration function for the Addaction team and also the data submissions to the local commissioners and the National Drug Treatment Monitoring System
- three non-medical prescribers (two full time and one working 22.5 hours)
- four nurse practitioners (three whole time equivalent posts) that provided the health and well-being functions of the service
- and five specialist doctors working across all the services, one was a locum and one offered flexible sessions.

The medical lead's working hours equated to four sessions. The medical lead did not deliver any clinical sessions with clients. Their role was predominantly on building partnerships, reviewing policies and procedures to ensure they fitted in with national guidance, and service development.

As of the 1 August 2016, the service reported a substantive staff turnover of 14%. At the time of the inspection, there was a part time pharmacist post and a service manager post vacant. Both were advertised. There was also a part-time non-medical prescribing role vacant. A nurse practitioner at the service was training for the role at the time of the inspection. The contract manager told us that it had been a challenge to find non-medical prescribers to work in the service and so the service had responded by supporting their existing nurse practitioners to fill these roles if they wanted to.

The provider had reported a total permanent staff sickness of 9% which equated to two members of staff and three periods of sickness, one of which was long-term.

Of the total 709 sessions available for all clinics (health and well-being and prescribing) between 1 May 2016 and 31 July 2016, 680 (96%) were covered by bank or agency staff. The service usually asked the sessional prescribers to cover additional shifts. Where the service used agency staff, they used regular agency staff that were familiar to the service for continuity of care. All agency use was controlled by Addaction's central business support hubs to ensure a co-ordinated approach towards the use of agency staff, and to ensure the staff used were qualified and competent.

Addaction Bradford clinical support services had a mandatory training compliance of 98%. Most mandatory training had a compliance rate of 100% for the staff that were required to complete it. Mandatory training included safeguarding adults and children, infection control, vaccinations and immunisations, medicines management, health and safety, equality and diversity, safeguarding information, naloxone use (naloxone is a medication used where a client overdoses on an opiate), and Mental Capacity Act training.

The service offered opiate substitute prescribing on five host sites across Bradford per week, ranging from seven hours to 57 hours of clinic time, depending on the number of clients accessing the site.

The service offered health and well-being interventions including physical health screening and blood borne virus screening and interventions, at nine sites across Bradford, ranging from 1.5 hours to 27 hours of clinic time depending on the number of clients accessing the sites and the requirement of the service.

The service had a calculation for the number of staff it needed based on the numbers of clients in treatment, the minimum number of times each client was required to be seen (every 12 weeks in the prescribing clinics and every six months in the health and well-being clinics, and the time

required for each appointment depending on the complexity of the clients in treatment (either 30 minutes for clients with more complex needs including the initial assessment, and 15 minutes for non-complex clients).

The doctors or nurses did not have their own caseload of clients in the host services that they regularly managed the care and treatment for. Clients were booked in with any prescriber or well-being nurse by the recovery workers at the host sites based on the appointment availability and when the client could attend. Where clients had more complex needs, doctors or nurses could request that the client was booked their follow-up appointment with them. The women's service at the central hub in Bradford had the same prescriber for each clinic.

Addaction had a director on call rota should anyone working in a late clinic need support and advice and be unable to contact the medical lead or the contract manager.

Assessing and managing risk to clients and staff

We reviewed 16 client records and we saw that risk was discussed with the client throughout the clinical consultations with the doctors and nurses in the prescribing clinics and the health and well-being clinics. This was documented in the clinical notes. All risk was discussed with the recovery workers in the host services and it was their responsibility to complete the over-arching risk assessment for the client whilst they were in treatment, and also to co-ordinate the risk management plan. We saw discussions with recovery workers in the client records and actions tasked to the recovery workers. During the team meeting, staff discussed their own actions with regard to the risk management plans, for example contacting the mental health crisis team where a client's mental health was deteriorating.

Between the 4 August 2015 and the 5 August 2016, there had been no safeguarding concerns or alerts received by the Care Quality Commission in relation to the service.

Addaction had both a safeguarding children policy and a safeguarding adult policy for staff to reference. These included guidance on the types of abuse, staff responsibilities in relation to reporting abuse, national and local frameworks, and the training required for their role. All staff had completed training in relation to safeguarding children and adults, including level 4 safeguarding training. Staff discussed safeguarding at team meetings, with one meeting a month specifically for staff to reflect on their practice and discuss clients. The team meeting minutes we reviewed and the team meeting we attended all demonstrated discussions about safeguarding, including follow-up actions. The director of quality was Addaction's named senior lead on safeguarding and the nurse manager was the safeguarding lead for the local Bradford service. The nurse manager attended the external partnership safeguarding meetings where lessons learned are discussed. Staff attended child protection meetings as required. The staff we spoke to demonstrated a good understanding of safeguarding and provided examples of action taken in relation to this, for example where a parent had attended intoxicated with their child. Staff told us that they discussed clients' access to children and their capacity to care for children. The electronic patient recording system supported this work as the record was shared with the primary care GP, and included a section about children that all services could add to.

Addaction had a managing violence and aggression policy in place to guide staff in maintaining a safe environment for staff and people who attended the services. This included guidance for staff in maintaining personal safety, preventing conflict and aggression, how to recognise aggressions, site specific safety procedures, and other procedures to follow for follow-up, notifying organisations and what to do in specific situations. Staff were aware that aggressive or violent behaviour should be reported as an incident. The Addaction outreach and lone working policy supported staff in completing home visits, which included completing a risk assessment prior to completing the visit. However, the contract manager informed us that home visits were rare and only completed in exceptional circumstances. The service worked towards encouraging clients to attend. Staff discussed two home visits and the reasons for them at the team meeting we attended on the day of inspection.

The medicines management policy was included the role and the accountability of the prescriber, and details about prescribing.

When a client first started in treatment, the prescriber liaised with the GP about a client's existing medication. The prescriber could view this in the shared electronic record when an information share was agreed between the systems or send an electronic task to the GP to gain additional information. Supplementary to this the health

and wellbeing staff made a comprehensive assessment of all those entering treatment and collected medication information at that time. This was to ensure that there was no double prescribing of medication, and to ensure there was no contraindication with other prescribed medications.

Urine or oral swab tests were completed by the recovery worker at the host site prior to the client starting treatment to confirm drug use, and also every eight to 12 weeks to confirm drug use and treatment compliance in addition to self-report. This usually coincided with the client's 12 week review with the doctor. Breathalysers were also used to determine the client's use of alcohol, for example before picking up their prescription for medication. Examples were given where staff had advised that the client came back for their prescription as they were under the influence of alcohol. Addaction's drug testing policy was in line with the Department of Health guidelines on the frequency of testing, and provided guidance for its staff. There had been some issues for the recovery workers across the partnership with the alcohol breath level required by Addaction for clients to pick up their prescriptions for methadone or buprenorphine. This differed from the level required by the other partner organisations. However, Addaction and the medical lead worked with the partner organisations in the Bradford recovery system to resolve this and agree to work with clients on an individual basis regarding their level of intoxication and whether they should be offered a prescription. Recovery workers were required to consult with an Addaction doctor or nurse in these situations.

The pharmacy agreed between the recovery worker at the host site and the client, was responsible for dispensing the substitute medication like methadone or buprenorphine. They completed additional checks where clients were on supervised consumption regarding a client's intoxication prior to dispensing the medication. Supervised consumption is where the service agrees with the pharmacy that a pharmacist supervises the consumption of prescribed medicines, ensuring that the dose has been administered to the patient and consumed as required by the prescription. They also helped to re-engage clients when they were not attending appointments and notified the host service where a client had missed their medication and required a reassessment in order to reduce the likelihood of an overdose. The recovery worker at the host service would feed this back to the prescriber and discuss the appropriate action, including booking the client an appointment with an Addaction prescriber to re-start their prescription where they had been off their prescription for three days.

The doctors and the non-medical prescribers reviewed risk in relation to the prescribing regimes for opiate dependent clients. Initiation onto a substitute prescription, like methadone or buprenorphine, using other substances on top of the prescribed medication, also poor attendance, having no fixed abode, or children, could mean that a client would be prescribed a regime for daily supervised prescription collection. Daily supervised collection meant that a client had to attend the pharmacy on a daily basis for their medication.

The doctors and non-medical prescribers reviewed the medication and prescribing regime of all clients on an opiate substitute prescription for opiate dependency at a minimum of every 12 weeks in line with national guidance. They would review sooner where change had occurred or risk had increased, for example non-engagement, poly-drug-use and safeguarding concerns. The prescribing reviews relied on the recovery workers booking the clients in for an appointment with the prescriber. Prescribers told us that they asked the recovery workers to book in at the tenth week so that the client was likely to attend within the 12 weeks. Addaction collected data on the clients who had been seen for the 12 week review for commissioners. However they did not use the information proactively to monitor and plan the 12 week reviews to ensure clients were booked in by the recovery workers. They relied on the individual staff and partner services and at the time of the inspection all clients had this review within the 12 weeks.

We reviewed practices around prescription storage. The main administrator was one of the two key holders who could access the prescriptions and sign them out to practitioners from a locked storage drawer. This was witnessed by two people. Whilst observing the practice a recovery worker from a partner organisation attended the service and requested five boxes of prescriptions. It was unclear where these were being taken initially and we were later told that they were being taken downstairs for use in the host service within the same building. The service recorded the first and last serial numbers of the pads but did not record the serial numbers of the prescriptions actually given to the patients. Therefore they would not be able to identify details if there was a lost or stolen

prescription. They were working with their partners to introduce a system around the recording, storage and transportation of prescriptions as staff at Addaction agreed that their systems could be more robust and safe.

The recovery workers at the host sites produced the prescriptions for the clients in line with the treatment plan agreed with the Addaction prescriber at the prescribing appointment. However, if a client attended the service and wished to have a change in their prescription, then the recovery worker could change the 'management plan' of the client and produce a new prescription without the client being seen by the prescriber. Addaction had recently introduced a system in September 2016 where the recovery worker was required to complete a detailed form to ensure that the prescriber had agreed to all the changes to prescriptions. This process was to ensure that the prescriber reviewed the client treatment record before signing the prescription and to ensure safe prescribing. Also, the service was trying to move away from emergency prescriptions but rather clients having planned appointments and prescription changes. Addaction had also built time into the prescribing clinics for the recovery worker to approach the prescriber to discuss a client's treatment with them, check the client's record, and to sign the prescription. We observed clinical governance meeting minutes that discussed the training for this new process and its implementation. We also saw team meeting minutes where the success of the new process was discussed, as well as problems encountered. The contract manager confirmed that the new process was still being embedded. We had a concern that during the inspection, a doctor allowed the recovery worker to enter an appointment whilst they were already in an appointment with a client, and sign a prescription for another client. The doctor did not check the client treatment record or other relevant information to confirm that the prescription was as planned.

All clients who were prescribed over 100ml of methadone had to have an electrocardiogram. The electrocardiogram measured for potential heart abnormalities which clients on high dose medication had an increased likelihood of suffering. This was in accordance with national guidance (Department of Health, 2007). Staff referred clients to their own GP for these electrocardiograms as the Addaction staff did not complete these. However, the process of whether attendance was followed up was not clear. The contract manager told us that this relied on individual staff following this up. There was no evidence that the service monitored the clients who required an electrocardiogram, when they were required, and whether the clients attended their GP and had this completed.

We observed information relating to medication and the impact that this may have on the client's ability to drive or cycle, and the client's responsibilities with regard to notifying the Driver and Vehicle and Licensing Authority. Records we reviewed demonstrated discussions around driving and informing the Driver and Vehicle and Licensing Authority. Staff also discussed the safe storage of medications with clients.

Nurses in the health and well-being clinics completed physical health assessments with clients at the beginning of treatment and every six months after. This enabled staff to manage risk in relation to clients' physical health. They would treat wounds and make onward referrals for sexual health, hepatology, or other conditions. Nurses completed blood borne virus screening to reduce the risk of blood borne virus transmission in the community, and also to prevent or treat clients that had a blood borne virus. Addaction had a blood borne virus policy which included screening, vaccinations, advice, and onward referral procedures. This policy included guidance for staff taking blood. The policy stated that suitably qualified nurses could conduct blood borne virus testing by methods such as drawing venous blood or using dried blood spot samples. The service did not have a procedure in relation to clients taking their own blood samples whilst in the service. However, during the inspection, we were concerned that a client took their own blood sample rather than the specialist nurse whilst an inspector was present. We discussed our concerns with the contract manager who told us that this was something the service did not allow.

The service had access to specialist medical care as required via the Bradford Royal Infirmary Hospital. It also had links with the mental health crisis intensive home treatment team to discuss clients who presented with a full diagnosis. A dual diagnosis worker commissioned from another area and service attended the team on a regular basis to support the team with any challenges or advice around dual diagnosis. Out of hours and physical health emergencies were managed by the emergency department at the Bradford Royal Infirmary Hospital and a GP walk in service.

Track record on safety

Substance misuse services

Addaction reported 12 serious incidents requiring investigation in the 12 months prior to 5 August 2016.

There were 31 medicines management related incidents between 1 April 2016 and 31 October 2016. We observed a detailed spreadsheet that recorded the dates of these incidents, details of the prescribing incident, and outcomes and recommendations following the incident. All types of errors were reported including more than one prescription in circulation, wrong doses dispensed, systems following missed medication doses not being followed, and lost or stolen prescriptions. The investigations indicated where the error had occurred in the Bradford recovery system, including at the pharmacists, or when a prescription was the responsibility of the client. Outcomes and recommendations observed following incidents included further training, discussions in supervision, working with partner agencies to improve the process. There were examples of improvements made to the processes, including additional time built into clinics for prescribers to sign prescriptions and have discussions with recovery workers. However, there remained concerns about security of the prescriptions and the safety of the prescribing.

There were no concerns regarding the provider in the most recent reports by the coroner in relation to the prevention of future deaths.

The provider has stated that there have been no reports or action plans resulting from serious case reviews undertaken at the service within the last 12 months.

Reporting incidents and learning from when things go wrong

All staff understood what types of incidents they should report, and gave examples that included deaths, injury, prescribing errors, and aggressive or violent behaviour.

All staff could report incidents using the electronic incident recording system. Guidance for staff for reporting incidents was available in the Addaction incident reporting policy. We saw examples of incidents reported, investigations where appropriate, and outcomes. An example included an incident which resulted in managers at the services revisiting staff personal safety when leaving the service.

Staff discussed incidents in supervision and learning was fed back via the multidisciplinary team meetings. We saw examples of this in the team meeting minutes, as well as the team meeting we attended during the inspection, where updates were given on the vaccines fridges.

Serious, untoward or critical incidents were reviewed by Addaction's regional hub for Bradford clinical support service, and the critical incident review group. The critical incident review group met on a monthly basis and reviewed and analysed any themes in incidents across Addaction. These would be cascaded back to the staff via the contract/service managers.

Staff told us that debriefs were completed following an incident if it was required, for example, following an unexpected death.

At the time of the inspection, Addaction's partner organisations all completed their own investigations into incidents. There was some shared learning at the clinical governance groups.

Duty of candour

Addaction had a policy on being open and duty of candour. This included the procedure for staff to follow, including the types of incidents where the duty of candour would be applied in line with the regulation.

Staff gave examples of being open and honest with clients when incidents or mistakes happened. They were aware of the need to keep clients fully informed and provided information throughout any investigations or complaints made, in line with policy. We saw responses to concerns raised about a delay in a client receiving their prescription.

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

Assessment of needs and planning of care

Recovery workers completed comprehensive assessments. They were completed in the two hubs; one in Keighley and one in the centre of Bradford.

We reviewed 16 client records with regard to the clinical assessments completed by the Addaction medical and clinical staff. The clinical assessments completed by doctors and non-medical prescribers were detailed and included assessments of the client's physical and mental

health and social circumstances. Addaction had a local target to review clients' medication every 12 weeks. Fifteen out of the 16 records we looked at showed that medication reviews had been carried out every three months as required. Each review explained the decisions made about a client's prescription. We made staff aware during our inspection of the one client record in which a three months review did not appear to have been completed. The contract manager took appropriate action.

Clients had physical health assessment appointments at the beginning of treatment with a health and well-being nurse, and then a physical health review every six months. Physical health assessments were comprehensive and included reviewing the client's general well-being, their drug and alcohol use including smoking, and calculating their body mass index. The nurse reviewed their blood borne virus status and offering screening and appropriate interventions. Nutrition, sexual health and contraception, skin conditions, and self-harm and injecting sites were also included in the assessment. Twelve of the 16 records we reviewed contained a physical healthcare assessment that met the six months review target. However, one record showed a client's last assessment was in August 2014, a second record showed a client's last assessment was in July 2015 and a third record contained no physical healthcare assessment details at all. We informed the contract manager who later informed us of the action they had taken to address this.

Most of the records reviewed showed evidence that staff encouraged client participation in psychosocial workshops, and other recovery support.

Addaction had recently implemented a treatment agreement that the clients signed and agreed when they entered prescribing treatment. This was to ensure that clients understood their rights and responsibilities with regard to treatment, and that treatment was safe and meaningful.

Addaction staff inputted information onto a client's electronic care record. The same electronic care record was used by the three partner organisations in the Bradford recovery system, and the majority of primary care GPs in Bradford, which supported communication regarding clients' care. Access to these systems was password protected. Information systems, governance and the policies and procedures were included in the staff induction. If the system could not be accessed for any reason, for example if it crashed, Addaction had a contingency plan to access the electronic record system at alternative sites so that they could continue to provide a safe service.

Best practice in treatment and care

We reviewed the prescribing and treatment policy in relation to prescribing for opiate dependence and medicines management. The policy and contract was underpinned by National Institute for Health and Care Excellence guidance and Public Health England evidence based standards.

Clients receiving support for their opiate dependence were offered a choice of medication between methadone and buprenorphine, and relapse prevention medication, like naltrexone to prevent a relapse. Clients' medication was reviewed every 12 weeks or more frequently if they had started treatment, were reducing or had complex needs with increased risk. We observed medication reviews within the 12 week period in all but one of the client files that we reviewed. Clients were given harm minimisation advice, offered blood borne virus testing, immunisation and signposted to treatment. Addaction's expectation was that clients engaged in psychosocial interventions before they entered into pharmacological treatment, and also whilst they were in prescribing treatment. Staff were able to quote the best practice guidance that was appropriate to the treatment and care delivered, including the National Institute for Health and Care Excellence (2007) clinical guideline 52 for opioid detoxification and the Department of Health (England) (2007) Drug misuse and dependence: UK guidelines on clinical management and the development of administrations.

All clients were offered a physical health assessment by the well-being nurses, including a physical and mental health screen, advice and information and an onward referral to an appropriate services, for example the GP or sexual health service. The service aimed to review clients' physical health every six months. Addaction offered smoking cessation, which is a comprehensive support programme, and use of nicotine replacement therapy.

Addaction completed some clinical audits. Two medical staff had independently undertaken audits related to their client group, and one member of staff told us an audit of sharps in clinical rooms had recently been undertaken. Fridge temperatures at the host sites were also audited, as

was hand-washing, cleanliness and infection control. Findings from audits were discussed at team meetings and were sent to staff by e-mail. However, a regular clinical audit programme was a challenge for Addaction as the electronic records were not the property of Addaction, which gave rise to information governance issues. We saw evidence that the provider was raising this was the commissioners and their partners in the Bradford recovery system. We were also told that as part of supervision, the supervisors would review a sample of the client records and treatment.

Client progress and changes were measured using the treatment outcome profile. This was completed by the recovery workers at the host sites in the Bradford recovery system. This is a monitoring tool developed by the National Treatment Agency for staff to use throughout treatment with clients and the information is reported through the National Drug Treatment Monitoring System. Public Health England then provides both national data, and local outcome data for the Bradford recovery system, which includes Addaction, which is presented in the diagnostic outcomes monitoring executive summary.

Skilled staff to deliver care

There was a range of multi-disciplinary professionals employed by Addaction to deliver treatment and care to clients for Addaction in the Bradford recovery system. This included doctors, non-medical prescribers, and nurses that were employed as health and well-being. These staff members worked across Bradford in the host services.

We reviewed four staff personnel records that included staff personal and training details, competencies they had completed, professional qualifications, registrations, and disclosure and barring checks. A number of staff had transferred to Addaction under Transfer of Undertakings (Protection of Employment) Regulations 1981 arrangements when they won the tender for the clinical service provision in the Bradford recovery system. Where appropriate we observed staff checks following their transfer to Addaction under this arrangement to confirm identity and competence.

Addaction had systems in place to manage and monitor staff registration and the continuous professional development required for their registration. As of the 1 August 2016, the three doctors employed by the service had been revalidated.

All staff completed a staff induction at the start their employment and we observed the comprehensive induction checklist in the personnel files, which included details of Addaction's policies and procedures. The service also had a six month probation period to new staff to ensure that they were competent in their role and if they needed any additional support. We observed induction checklists and probation reviews as appropriate in the four personnel files that we reviewed.

In the 12 months prior to the 1 August 2016, 50% of permanent non-medical staff had an appraisal. However, all staff were not at the point of an annual appraisal due to their length of time working for the provider. We observed professional development reviews (appraisals) started in three of the four personnel files that we reviewed.

Staff had managerial supervision that included case management and operational supervision with a named supervisor. Addaction's policy stated that 10 supervisions per staff member should be completed annually. Whilst all staff told us that they had regular supervision, in the four personnel files that we observed there was no evidence that supervision had been completed prior to April 2016 and then following July 2016. The contract manager told us that she had been aware of some disruption to the managerial supervision since the service manager was no longer in post. However, she confirmed plans to rectify this. Also, staff confirmed that the contract manager, medical lead and nurse manager were always available should they require a discussion about a client, their caseload or general support.

Addaction had just implemented clinical supervision for staff. All staff had a named person that provided them with management and clinical supervision. The medical lead supervised the doctors and the nurse manager, and the nurse manager supervised the non-medical prescribers and the nurses.

Addaction had weekly team meetings, with one per month dedicated to safeguarding. Team meetings were used to discuss operational procedures, and also as opportunity to discuss clients, best practice and challenges. We observed detailed discussions in the team meeting minutes that we reviewed for the two months prior to the inspection. We also attended a team meeting during the inspection, where there was case discussion about clients and practice with input from all the Addaction team, as well as updates on safeguarding and the new procedures implemented.

In addition to the mandatory training, staff told us that specialist training was also available to ensure that had the right skills, knowledge and experience to fulfil their role. Staff told us that the service encouraged and supported their training and development. Specialist training included vaccination training, key principles for working with people who misuse substances, prescribing for opioid dependence, motivational interviewing, mutual aid partnership, communication and customer service.

The prescribers had completed the level one and two Royal College of General Practitioners specialist training in substance misuse.

The nurse manager and contract manager had completed nationally recognised leadership and management courses.

Addaction had a capability policy and procedure that supported managers in addressing poor performance, and employees with understanding this process. However, no one was subject to capability proceedings at the time of the inspection.

Multidisciplinary and inter-agency team work

Addaction worked in partnership with three other organisations to deliver care and treatment for substance misusers as part of the Bradford recovery system. Recovery workers in the host services worked closely with the Addaction doctors and nurses, and they attended the prescribing appointments with the clients. All the records we reviewed demonstrated this partnership approach and these three-way appointments. Recovery workers also had the opportunity in each prescriber's clinic to discuss a client's treatment.

Staff told us that they had a good relationship with GPs, walk-in centres, pharmacies, and specific teams in the local trusts, including hepatology, the crisis services and mental health teams. They also worked with other statutory agencies to support clients including with the probation service, the police, the prisons and social care, as well as and non-statutory agencies and voluntary organisations, like a local organisation that supported sex-workers. Staff described examples of how they had liaised, and worked with, these agencies during the team meeting, for example a client where there was mental health concerns. Records we reviewed showed evidence of staff working in partnership with other external professionals.

Good practice in applying the MCA

The Mental Capacity Act is a piece of legislation which enables people to make their own decisions wherever possible and provides a process and guidance for decision making where people are unable to make decisions for themselves.

Training on the Mental Capacity Act was mandatory for all staff and included e-learning courses provided by the Social Care Institute for Excellence. All staff that were required to complete this training had done so.

The safeguarding adult policy contained information about the Mental Capacity Act, principles of the Act, and demonstrating decision-making capacity, to inform and guide staff. Staff also told us that Addaction had its own mental capacity act policy that could be accessed using the service's intranet.

Most of the staff we spoke with had a good understanding of the Mental Capacity Act including the five statutory principles and also the application of the Act within their role. They were aware of the need to presume a client has capacity, to note the client's ability to weigh up decisions and understand information and to make decisions in the client's best interests if they lacked capacity. They gave examples where they would consider a client's capacity where they were intoxicated to consent to treatment or to receive their prescription for medication and the action that they would take. Information about a client's capacity, and any decisions made, were recorded on the client electronic recording system.

Staff confirmed that if they needed any advice on decisions around capacity they would discuss this with the nurse manager who was the safeguarding lead, or the medical lead.

Addaction did not have arrangements in place to monitor the application of the Mental Capacity Act.

Equality and human rights

Addaction had a diversity and equality procedure which included the protected characteristics in relation to considerations regarding the clients who use their services, their service delivery, and the staff they employ. The service told us how they had amended working hours for staff and recruited in a way that ensured they did not discriminate against individuals in relation to gender, disability, sexual orientation, religion, belief, race, pregnancy, or age. All

Substance misuse services

Addaction policies had recently been subject to equality impact assessments to ensure that they did not discriminate against clients with protected characteristics that were covered by the Equality Act 2010.

All staff were required to read the diversity and equality procedure as part of their induction. Seventy-five percent of staff had completed the mandatory safeguarding equality and diversity training, and the service was in the process of sourcing equality and diversity training specifically in relation to the local region at the time of the inspection.

Staff worked in a person centred way with clients from a range of different backgrounds and with clients who had protected characteristics. During our inspection we observed that staff worked in a way to ensure that all clients received equal treatment and access to services.

The service offered a women only service and was in the process of developing a perinatal service for pregnant clients with another partner agency, including one to one support with one named clinician and recovery worker, and a specialist midwife. The service was also working closely with local services to ensure that the care and support offered was available and appropriate for clients who were seeking asylum in this country, and clients from the lesbian gay bisexual and transgender community.

Bradford has a diverse population and Addaction ensured that culture and religion was not a barrier to drug treatment. For example, staff reviewed clients' treatment plans and prescription collections during Ramadan where clients may wish to fast.

Management of transition arrangements, referral and discharge

Clients accessed treatment for their substance misuse through dropping in to one of the hubs in the Bradford Recovery Systems. There was one hub in the centre of Bradford and one in Keighley. Clients could also be referred by their GP other agency or professional.

Clients did not directly access the prescribing services and the health and well-being services delivered by Addaction. They were first assessed by the recovery workers working for the partner agencies, known as the host sites, who delivered the psychosocial interventions in these hubs.

Following this assessment, and depending on a client's individual need, a client was booked an appointment with a prescriber for a substitute prescription and a physical health assessment by a recovery worker at the host site. The locally agreed target was that all clients were seen for both prescribing assessment appointments and physical health assessments within five days and Addaction regularly met this target.

The clients attended the hubs until they became more stable, including on their substitute prescription and attending appointments, they were then given a choice of which local services in the Bradford Recovery System they wished to attend. This was usually following the first 12 weeks of treatment. The recovery workers at the host sites would facilitate this transition. All transitions were seamless with regard to prescribing and physical health. Clients were booked in with a prescriber or a nurse by the recovery worker to continue their care in line with the client's treatment plan. These transitions were supported by the use of one single electronic record system.

When clients no longer needed a pharmacological intervention from Addaction, they could continue to receive ongoing psychosocial interventions from recovery workers based at the host sites. Post recovery, clients were encouraged to become peer mentors and volunteers within the recovery hub that was part of the Bradford recovery system.

Clients we spoke to were aware of the process and that they would move to another service from the hub as part of their recovery when they were engaging in treatment and stable on their medication. Despite doctors and nurses working for Addaction, and recovery workers working for other organisations, clients saw the services as one service that delivered their care and treatment.

Are substance misuse services caring?

Kindness, dignity, respect and support

We spoke with clients who accessed the Addaction clinical support services in Bradford, and we received 31 comment cards. Most of the clients told us that the doctors and nurses were kind, caring and respectful towards them. However, there were three negative comments from clients regarding the perceived attitude of staff towards them.

During the inspection we observed seven clinic sessions, including five prescribing clinics and two health and well-being clinics. We observed a good rapport between the staff and clients. Staff demonstrated a

non-judgemental attitude towards the clients, and an empathic understanding of their individual situations. For the most part we observed examples of good practice where Addaction staff worked with a commitment to maintaining client confidentiality, privacy and dignity. However, we had a concern that during a clinic appointment where a prescriber was completing a medical review with a client, a recovery worker entered the appointment at the agreement of the prescriber to have another client's prescription signed. The recovery worker was employed at the host site by one of Addaction's partner organisations in the Bradford recovery system. This compromised the privacy and level of respect shown towards the client in the appointment, and had the potential to breach the other client's confidentiality whose name would have been on the prescription.

We observed the Bradford recovery system consent to share information form used at all the host sites in the Bradford recovery system at the start of the clients' treatment. This included how information would be shared with organisations in the recovery system, as well as with the National Drug Treatment Monitoring System. The client could agree on the type of information that would be shared and with who, and the circumstances where information may be shared without the client's consent.

The involvement of clients in the care they receive

During our inspection, we spoke with people who used the service and they told us that their treatment options were explained to them, and they were involved in decisions about their care. Staff told us that they discussed the treatment options with clients and encouraged them to attend other services where necessary. There were examples where clients did not agree with their treatment plan, particularly around the dispensing arrangement at the chemist. However, these were risk-based decisions regarding the prescribing of a controlled drug, which were documented in the care records. Also not all clients said that they were encouraged by the clinical staff to reduce their medication: one client told us that she had initiated those discussions.

The clients that we spoke with had not been asked if their relatives or carers wished to attend their appointments but they presumed that this would not be a problem. Staff told us that if a family member wanted to attend an appointment and the client agreed, then that would be facilitated. However, generally it was the responsibility of the recovery workers at the host sites to encourage relative and carer involvement, and to ensure that consent was obtained and documented.

The service had contacts with various local advocacy services and staff told us that they would support clients to access these if it was required.

Between April and May 2016, Addaction completed a service user engagement review, which included responses from 500 people involved in activities and events in services across the UK and out in the community. The aim was to bring people together to inform the organisation about what it should keep doing, stop doing and start doing. The outcome of this service engagement review was on the Addaction internet and cascaded to staff, with individual services pledging changes to provision in line with the outcomes, for example focusing on the therapeutic relationship and group activities.

Locally, we observed Addaction client feedback forms at the host site where we completed the inspection in Bradford, which were collected weekly and fed back to the staff and the clients. The feedback forms included four real time questions and we observed the outcomes for these for the week we inspected, as follows:

- 73% rated their satisfaction of the service provided to them that day as excellent and the rest rated it as good
- all service users would recommend the service to a friend
- 53% of clients saw a healthcare nurse and 47% saw a prescriber
- 93% of clients rated the friendliness of staff as excellent and the rest rated it as good.

Addaction involved clients in recruitment in the organisation nationally but had not yet involved clients in recruiting for staff at this location.

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

Access and discharge

Substance misuse services

Addaction worked with adults 18 years and older who were misusing drugs. They would also work with clients who were misusing alcohol in addition to their drug dependence. However, alcohol interventions were usually delivered by other organisations in the Bradford recovery system. On the 1 August 2016, 2307 clients were accessing Addaction services.

Addaction had two local quality indicators agreed with the commissioners relating to clients being able to access the service in a timely way. All clients were required to be seen for both prescribing assessment appointments and physical health assessment appointments within five days. Between 1 April 2016 and 30 September 2016, Addaction met this target for all prescribing assessment appointments. They met this target for three out of the six months for physical health assessment appointments. For the other three months 99% of clients were seen for a physical health assessment within five days. According to the diagnostic outcomes monitoring executive summary, between 1 April 2016 and 30 June 2016, the Bradford recovery system which included Addaction, was performing better than the national average. It had wait times less than three weeks to access interventions, with no patients waiting more than three weeks.

The diagnostic outcomes monitoring executive summary showed that between 1 April 2015 and the 31 March 2016 the Bradford recovery system had made improvements in the number of patients leaving the service in a planned way as a proportion of those in treatment, and not re-presenting in the last six months. However, the system was performing below the national average. As of the 31 March 2016, the average length of time in treatment across the Bradford recovery system was 5.5 years. This was also above the national average of 4.7 year. However, the performance of the services in Bradford was consistent with other similar services in the north of England. Addaction worked with other organisations in the recovery system, and the commissioners, to reduce the length of time clients were in treatment, and to increase the number of clients leaving the services in a planned way and not re-presenting.

Clients told us that the recovery workers at the host sites booked them clinic appointments with the prescribers and health and wellbeing nurses that was convenient for them, and took into consideration other lifestyle factors, like work or family. Clients and staff said that clinic appointments were rarely cancelled, particularly the prescribing clinics which were almost always covered. Where physical health clinics were cancelled, attempts would be made to reschedule these clinics, particularly at the busier host sites, rather than just cancel altogether. Several clients commented that sometimes the clinic appointments over-ran, which made their appointment later than scheduled. They commented that if they were running late for an appointment, they may not be seen and suggested that this was not equitable.

Between the 1 August 2015 and 31 July 2016, clients did not attend 2162 prescribing appointments across all the organisations in the Bradford recovery system, and 1556 healthcare appointments. Addaction had a 'did not attend procedure' for staff to follow in the prescribing service. This included the course of action to take when clients did not attend for their prescribing appointments, including when to offer another appointment and considerations around prescribing medication. Where this procedure was not followed, an incident form was submitted. We saw evidence of this on the medicines management incident spreadsheet submitted by the provider. Addaction staff worked together with the recovery workers at the other host sites to positively engage clients in treatment.

The facilities promote recovery, comfort, dignity and confidentiality

Clinic rooms were available for Addaction staff at the hubs and the host sites for both the prescribers and for the health and well-being nurses. All intimate procedures were carried out in a private room to ensure privacy and dignity to service users. At the sites we visited during the inspection, there were designated rooms for screening for blood borne viruses and also for drug testing clients.

Staff told us that the rooms they worked in at the host sites were adequately sound proofed to ensure conversations were confidential. The rooms we observed during the inspection at one of the host sites had frosted glass over the door windows and were adequately sound proofed to maintain privacy and confidentiality.

We observed information available for clients on medication including methadone and 'Subxone,' which is a type of buprenorphine medication. Both medications are substitute medications used for opiate dependency. The leaflets included detailed information about the medication, the side effects clients may experience, and

the potential risks of using the medication. The leaflets also included the implications for cycling or driving when using these medications. There was also a perinatal leaflet that had been developed for clients who wanted to get pregnant or who were pregnant in relation to their medication and the impact on the foetus's development and breastfeeding.

Meeting the needs of all clients

There was a hub in Bradford and a hub in Keighley, and host sites across Bradford and Airedale, where Addaction provided specialist prescribing and health and well-being interventions. Following the first 12 weeks in treatment, clients could access a service of their choice. This enabled equitable access for all patients regardless of geographical constraints.

Addaction held one late night prescribing clinic at five host sites. They also held a women's clinic every Thursday evening in one of the central host sites.

Where clients were unable to attend the host sites, for example due to a physical health condition that prevented them from attending, Addaction staff would facilitate home visits. During the team meeting we attended, staff gave examples where they had completed recent home visits. Addaction's partner organisations in the Bradford recovery service were responsible for ensuring clients with a disability could access the service. This included the use of a ramp at some sites.

Staff could access language line for clients whose first language was not English. Staff could provide a sign language interpreter for deaf clients. However, in most cases this would be arranged by the recovery workers at the host sites.

We observed leaflets on treatment available in the different languages spoken by people who use the service. For example, we observed leaflets about methadone and buprenorphine in Lithuanian, Punjabi and Urdu. The contract manager told us that information and documentation was translated as required using an online translation system.

Information on groups, service user involvement, and accessing additional support, for example around mental health, was available on the Addaction website.

Listening to and learning from concerns and complaints

Eight formal complaints were made between 1 August 2015 and 31 July 2016. Five (63%) of these were upheld. Of the eight complaints received, none were referred to the Parliamentary and Health Service Ombudsman. There had also been eight compliments received by the provider in the same time period.

Addaction had a complaints and feedback policy which included the procedure for staff to follow and the timescales required for responding. The contract manager told us that all complaints were investigated and dealt with within a deadline of 20 days and that a response is given in writing to the complainant.

We reviewed two of the complaints received in the last 12 months. Both the complaints included details of the action taken by the service with regard to resolving the complaint, as well as the outcomes and learning from the complaint, and actions and recommendations for the service. A standard form was completed for each complaint. Recommendations from these complaints included increased communication with clients when they have an unplanned prescribing change and increase across the system, and also increased three-way working specific to the client that had complained.

We observed Addaction complaint forms in all clinical rooms and complaints information was also available on the Addaction website. Staff stated that they encouraged clients to complain and would support them to do this. Clients told us that they knew how to complain and would speak to a doctor or nurse if they wanted to.

Addaction's complaints were monitored locally and by its critical incident review group, who analysed them to find trends. Staff would review all learning from complaints in team meetings and through supervision.

Are substance misuse services well-led?

Vision and values

Staff were aware of the Addaction values; being compassionate, determined and professional. They could describe the behaviours that underpinned them. The contract manager told us they had recently revisited the values with staff in the organisation including examples of behaviours that the organisation wanted to see, were pleased to see, and that they did not want to see.

Addaction also had five guiding principles. These included being collaborative, ethical, inspiring, resilient and self-challenging. The managers and the medical leads described their approach in delivering the service within these guiding principles, particularly in their approach to working in partnership with other organisations which were part of the Bradford recovery system.

Staff knew who senior managers were. They told us that the contract manager spent regular time in the service each week and that other senior managers supported activities in the services, like interviewing. The Addaction chief executive and medical director had visited the service.

Good governance

Addaction provided the clinical support services for the Bradford recovery system. They worked in partnership with other services to deliver the treatment and care. All of Addaction's clinical services were underpinned by Addaction's comprehensive integrated clinical governance structure, which was overseen by the board of trustees, but driven by the senior leadership team and clinical and social governance group. The contract manager told us that there was an integrated clinical governance structure in place. However, we were told that some of the meetings to discuss the integrated care had lapsed recently, and some of the systems were not yet integrated, for example reviewing incidents and deaths, and cascading learning. We reviewed minutes of two clinical governance meetings (one in January 2016 and one in September 2016) where the local commissioners and representatives from the partner organisations attended. Discussions about the recently introduced prescribing process, deaths and the pregnancy service were held. At a strategic level the partnership appeared to be more of a challenge for example with regard to access the electronic recording systems to complete audits as another service owned the system and the information. There was also an issue with the service providing us with contact details of clients and carers. We saw evidence that the service worked with the partners to resolve these issues. However, systems and partnership working at service level appeared cohesive and seamless, with good partnership working.

Between November 2015 and April 2016, senior managers and internal quality auditors who were not located at the service undertook four quality visits. These included an internal audit of the service, including safety, quality and prescribing. However, clinical and medication audits were not completed on a regular audit schedule to review the safety and quality of the service. The service did not routinely collect data to ensure that clients, who were required to have an electrocardiogram, had attended the GP and had it completed, or to help clinicians identify when it was due. Where they did collect data, they did not use it proactively to identify when the prescribing reviews were due and to ensure action was completed, for example the 12 week prescribing reviews.

Systems were in place to ensure that staff complied with mandatory training. Clinical supervision had just started at the service and there had been a lapse in the management supervision in the last few months, which the contract manager was aware of. This had lapsed due to the service manager no longer being in post and there had been no contingency for this with regard to staff supervision. However, team meetings were held weekly and attended by all Addaction staff and peer discussions about clients and procedures were observed. Staff could access advice and support in child and adult safeguarding.

Systems were in place to monitor complaints and incidents across the service and these were investigated where appropriate. Lessons learnt and best practice was cascaded to the teams via team meetings. This information, as well as client and staff feedback was used to inform service provision.

The key performance indicators for the service were set by the local commissioners. Each quarter Addaction provided data to the local commissioners on their outcomes and were performing well on these targets. The service had improved the services performance since August 2016 and was maintaining its performance for seeing all clients seen within five days for a health assessment and a prescribing assessment, and being seen every 12 weeks for a medical review.

All staff told us that they could raise issues and discuss them with their managers in team meetings and in supervision.

Addaction had a national risk register but at the time of the inspection Addaction clinical support services did not have a local risk register. However, Addaction told us that they planned to implement a local risk register next month. We saw their risk register policy and procedure and the proposed documentation for the local risk register for managers to complete.

Leadership, morale and staff engagement

Addaction reported a total permanent staff sickness of 9% overall and a substantive staff turnover of 14% as at 1 August 2016. This was a small team and equated to two members of staff: one with a short period of absence and one which was more long-term.

Staff reported that they felt that the team was open to sharing ideas. Staff told us that they could share ideas in the team meeting and we saw examples in the team meeting that we shadowed, for example resolutions around a client safeguarding concern and the process of obtaining client blood results.

The service reported that there were no bullying and harassment cases. Staff stated they could raise concerns with their managers and that they would be listened to. Staff were aware of the whistle blowing policy and felt confident to use it.

Staff morale was good despite the recent tender process in July 2015 and the following restructure, as well as the up-coming tender of the recovery system in December 2016. The staff we spoke with, and those that responded through the five comment cards, said that they felt supported and that Addaction was a good service to work for. They said that they felt it was a service that was willing to learn and improve.

Addaction completed an annual staff survey and an annual recovery conference for front line staff. The contract manager told us that staff were encouraged to feedback and attend respectively. Staff could also be nominated for the monthly staff awards, which recognised staff achievements in the Addaction local services and were recognised at a national level by the organisation.

We saw evidence that staff could progress through the service, with Addaction encouraging the specialist nurses to complete the qualification to become non-medical prescribers.

Commitment to quality improvement and innovation

Between November 2015 and April 2016, senior managers and internal quality auditors who were not located at the service undertook four quality visits. They reviewed the governance systems and the service delivery.

Addaction had organised a peer support network for prescribers working in the northern Addaction services, including the Bradford service and the Hartlepool service.

The contract manager participated in a national research group reviewing the toxicity of new psychoactive substances, including 'legal highs.'

The role of the medical lead focused on building partnerships, reviewing policies and procedures to ensure they fitted in with national guidance, and service development. The medical lead had identified a gap in current provision for pregnant women. The medical lead was working with other agencies to design this pathway for these women, where a prescriber, recovery worker and a specialist midwife, worked together as a team around each client to support them. Work was also in progress to improve clients' access to sexual health services, with clients being able to access treatment and care on site.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff follow their procedures with regard to the signing of prescriptions to ensure that the clients confidentiality and privacy is maintained, and that they are respectful to all clients.
- The provider must ensure that all prescribers review or check the care records of the client before signing the prescription or the check with the recovery worker at the point of signing the prescription.
- The provider must ensure that their policy is followed with regard to taking blood and screening for blood borne viruses.

Action the provider SHOULD take to improve

- The provider should ensure that the systems in place with regard to the transport, storage and recording of prescriptions are safe.
- The provider should ensure that all staff receive managerial supervision in line with their policy and have a contingency plan in place where supervisors are not available.
- The provider should ensure that the systems are in place to support staff to fulfil their role, and that service provision is safe and effective, including collecting and monitoring data to use proactively to manage the risks associated with prescribing medication.
- The provider should ensure that they continue to work with partners and commissioners to fully integrate governance at a strategic level with the partner organisations in the Bradford recovery system, including agreed clinical audit.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** A doctor did not review or check the care records of the client or check with the recovery worker at the point of signing the prescription. A client took their own blood despite this not being normal practice and not something the staff at the service practiced. There was no policy to support this practice. **This was a breach of Regulation 12 (2) (b)**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **How the regulation was not being met:** When the recovery worker from the host service came to get a client prescription signed, the doctor was in the appointment with another client – the doctor allowed the recovery worker to enter and signed the prescription during the appointment – this could have breached the confidentiality and privacy of the client whose prescription it was. Also it was not respectful towards the patient in the appointment and did not respect their right to a private appointment. **This was a breach of regulation 10 (2) (a)**