WDP Merton

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	**Good**
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Outstanding
Are services well-led?	Good

Overall summary

WDP Merton is a community-based alcohol detoxification and substitute prescribing service provided by Westminster Drug Project.

We rated WDP Merton as good because:

- The service provided safe care. The premises where clients were seen were safe and clean. The number of clients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each client the time they needed. Staff assessed and managed risk well and followed good practice with respect to safeguarding. All staff had completed safeguarding adults and children level 3 training on how to recognise and report abuse, and they knew how to apply it.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the clients and in line with national guidance about best practice, such as motivational interviewing and the International Treatment Effectiveness Project (ITEP).

Summary of findings

- The teams included or had access to the full range of specialists required to meet the needs of clients under their care. The service included a team of nurses, a doctor, non-medical prescribers, recovery practitioners, volunteer counsellors, administrators, managers and a Building Recovery in the Community Coordinator (BRIC).
- Staff completed comprehensive assessments with clients on accessing the service in a timely manner. Assessments covered drug and alcohol history, safeguarding concerns including social needs, risks, mental health care needs and physical health needs including sexual health needs.
- Clients informed us that they were treated with compassion, kindness, respect and their privacy was always respected. During the inspection we observed staff talking to clients in a caring and respectful manner.
- The service went over and above to ensure that clients working towards discharge had the necessary support in place. The service held a moving forward group, which was a 12-week programme that supported clients in working towards being discharged from the service and reintegrated back into the community. The service had a good working relationship with the local inpatient rehabilitation service for clients whose needs could not be met by WDP Merton.
- Staff were exceptional in recognising and responding to the needs of the local population. For example, the service had recognised that there was a large Tamil population that required support with alcohol misuse. The service employed a Tamil speaking apprentice to provide specific group interventions in Tamil. The service had translated information leaflets about the service into Tamil and Polish, in recognition that some clients within the local community may not be able to speak and read English as a first language.
- Staff had gone over and above in ensuring that clients had access to education and work opportunities. Clients had the opportunity to access an employment support programme created by WDP called Giving Something Back (GSB). Staff had established a partnership with a local job centre who provided monthly drop-ins at WDP Merton to provide advice and opportunities for clients to get back into employment.
- The service was innovative in creating a reward scheme to encourage clients, carers and families to engage with the service. Clients could collect points on to a card by attending groups within the service. They could then spend the points with partners within the local community who had signed up to the scheme. This meant that the service was rewarding client engagement through an earn and spend points system.
- Leaders could clearly demonstrate that they had the skills, knowledge and experience to perform their roles. The manager of the service had over 13 years' experience working in substance misuse services. Staff told us that leaders were visible in the service and approachable.
- All six staff we spoke with said that they felt respected, supported and valued by managers within the service. Staff spoke highly of the service manager and the operations manager and expressed that they felt positive and proud working within the team. Staff felt able to raise concerns with managers if they needed to.
- Staff success was recognised through a WDP award scheme. The staff team within WDP Merton had recently won an award recognising that they had gone the extra mile within the service.

Summary of findings

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Good

WDP Merton

Services we looked at
Community-based substance misuse services

Summary of this inspection

Background to WDP Merton

WDP Merton is a community-based alcohol detoxification and substitute prescribing service provided by Westminster Drug Project. The service provides a range of treatment that includes prescribing and community detoxification, specific alcohol treatment pathways, one to one support, group support, needle exchange and harm reduction. These services were previously provided by a different service provider within Merton before WDP Merton acquired this contract. At the time of our inspection, the service had 265 clients and 22 staff. There were six staff leavers in the previous 12 months due to the change in service provider.

The service has a registered manager with the Care Quality Commission. The service is registered by the Care Quality Commission to provide the regulated activity of treatment of disease, disorder and injury.

This was the first inspection of Westminster Drug Project Merton, since its registration in April 2018.

Our inspection team

The team that inspected the service comprised of two Care Quality Commission inspectors and one specialist advisor who had experience as a nurse in the field of substance misuse.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health and substance misuse inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- 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.

During the inspection visit, the inspection team:

- looked at the quality of the environment, visited the clinic rooms and observed how staff cared for clients
- spoke with four clients
- spoke with three carers
- spoke with the registered manager and service manager
- spoke with six other staff members; including, non-medical prescribers, recovery practitioners and a building recovery in the community coordinator (BRIC)
- attended and observed one daily planning meeting
- attended and observed a women's preparation for detoxification group
- looked at five care and treatment records
- looked at a range of policies, procedures and other documents relating to the running of the service

Summary of this inspection

- looked at supervision records and annual appraisal records.

What people who use the service say

We spoke with four clients and three carers. All four clients gave positive feedback and felt that they were always treated with kindness, dignity and respect by staff. Clients told us that staff supported them with their needs and with their treatment pathway.

Carers told us that staff were supportive in responding to their needs in addition to supporting clients' needs.

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?

Good

We rated safe as **good** because:

- All premises where clients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. One client told us that they found the reception area to be welcoming.
- The service had enough staff, who knew the clients and received basic training to keep them safe from avoidable harm. The number of clients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each client the time they needed. Clients told us that they were able to meet with their keyworker often.
- Staff completed comprehensive assessments with clients on accessing the service in a timely manner. Assessments covered drug and alcohol history, safeguarding concerns including social needs, risks, mental health care needs and physical health needs including sexual health needs. Care and treatment records showed that staff were meeting regularly with clients for one to one key working sessions.
- Staff understood how to protect clients from abuse and the service worked well with other agencies to do so. All staff had completed safeguarding adults and children level 3 training on how to recognise and report abuse, and they knew how to apply it.
- The service had a good track record on safety. The service managed client safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave clients honest information and suitable support.

Are services effective?

Good

We rated effective as **good** because:

- Staff developed personalised recovery plans that meet the needs of the client identified in the assessment. Staff ensured that plans were made in conjunction with clients and updated when there was a change in circumstances or presentation of risk. Staff developed a risk management plan for those people identified as being at risk that included a plan for unexpected exit from treatment.

Summary of this inspection

- Staff provided a range of psycho-social interventions to clients in addition to prescribing medication. Client could access one to one key working with their recovery worker, motivational interviewing, counselling, group work and the International Treatment Effectiveness Project (ITEP). The ITEP intervention aimed to improve treatment effectiveness. Clients were also offered a 12-step recovery programme called SMART. This helped clients to identify negative actions and thinking patterns that lead to addictive behaviour. It then offers clients a tools and techniques to support their recovery.
- The teams included or had access to the full range of specialists required to meet the needs of clients under their care. The service included a team of nurses, a doctor, non-medical prescribers, recovery practitioners, volunteer counsellors, administrators, managers and a Building Recovery in the Community Coordinator (BRIC).
- The service had weekly multidisciplinary meetings. Staff ensured that there was multidisciplinary input into clients' comprehensive assessments from, for example community mental health teams, GPs, maternity services, Children and Family services, social workers and criminal justice services. Recovery plans demonstrated input from other stakeholders and had clear care pathways to other supporting services, for example referring to housing support services.
- Staff supported clients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2008 and knew what to do if a client's capacity to make decisions about their care might be impaired.

Are services caring?

Good

We rated caring as **good** because:

- All four clients informed us that they were treated with compassion, kindness, respect and their privacy was always respected. During the inspection we observed staff talking to clients in a caring and respectful manner.
- Staff communicated with patients so that they understood their care and treatment, client received information leaflets upon accessing the service and attended groups. All four clients told us that staff helped them to understand their care and treatment plan.

Summary of this inspection

- Staff informed and involved families and carers appropriately. We spoke with three carers who confirmed that they were involved in the care and treatment of clients where appropriate. Clients were offered the opportunity to invite family members or carers to attend appointments with them.

Are services responsive?

Outstanding 

We rated responsive as **outstanding** because:

- The service went over and above to ensure that clients working towards discharge had the necessary support in place. The service held a moving forward group, which was a 12-week programme that provided support for clients who were working towards being discharged from the service and reintegrated back into the community. The service had a good working relationship with the local inpatient rehabilitation service for clients whose needs could not be met by WDP Merton.
- The design, layout, and furnishings of treatment rooms supported clients' treatment, privacy and dignity. The service had enough interview rooms for key workers to meet with clients in private and a television screen in the reception area which displayed information about services on offer to clients.
- Staff were exceptional in recognising and responding to the needs of the local population. For example, the service had recognised that there was a large Tamil population that required support with alcohol misuse. The service employed a Tamil speaking apprentice to provide specific group interventions in Tamil. The service had translated information leaflets about the service into Tamil and Polish, in recognition that some clients within the local community may not be able to speak and read English as a first language.
- Staff had gone over and above in ensuring that clients had access to education and work opportunities. Clients had the opportunity to access an employment support programme created by WDP called Giving Something Back (GSB). Staff had established a partnership with a local job centre who provided monthly drop-ins at WDP Merton to provide advice and opportunities for clients to get back into employment.
- The service was innovative in creating a reward scheme to encourage clients, carers and families to engage with the service. Clients could collect points on to a card by attending groups within the service. They could then spend the points with partners within the local community who had signed up with the scheme. This meant that the service was rewarding client engagement through an earn and spend points system.

Summary of this inspection

- The service had a clear and robust complaints system to show how complaints are managed and lessons are learnt and acted upon to improve the quality of the service.

Are services well-led?

Good

We rated well-led as **good** because:

- Leaders could clearly demonstrate that they had the skills, knowledge and experience to perform their roles. The manager of the service had over 13 years' experience working in substance misuse services. Staff told us that leaders were visible in the service and approachable.
- Staff knew and understood the vision and values of the team and wider organisation and their role in achieving that. The service had a local strategy map which linked the values of WDP centrally to the goals, mission, vision and delivery model of WDP Merton.
- All six staff we spoke with said that they felt respected, supported and valued by managers within the service. Staff spoke highly of the service manager and the operations manager and expressed that they felt positive and proud working within the team. Staff felt able to raise concerns with managers if they needed to.
- Staff, clients and carers had access to up-to-date information about the provider. The service produced a monthly newsletter which provided information on the services on offer as well as other informative advice for clients. For example, the November newsletter highlighted that it was alcohol awareness week within that month and also detailed a new outreach project to be provided by WDP Merton.
- The service participated in WDP's 'bright ideas' scheme, which rewarded staff who produced innovative ideas that could be implemented across WDP. This meant that the service encouraged innovation from staff to further develop the service. The staff team within WDP Merton had recently won an award recognising that they had gone the extra mile within the service.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff had completed training on the Mental Capacity Act, which included training on capacity and consent. Staff understood mental capacity and were aware of how substance misuse can affect capacity. Staff worked under the principle that capacity is always assumed and would assess a client's capacity when this was queried.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community-based substance misuse services	Good	Good	Good	☆ Outstanding	Good	Good
Overall	Good	Good	Good	☆ Outstanding	Good	Good

Good

Community-based substance misuse services

Safe	Good
Effective	Good
Caring	Good
Responsive	Outstanding
Well-led	Good

Are community-based substance misuse services safe?

Good

Safe and clean environment

All premises where clients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. One client told us that they found the reception area to be welcoming.

Clients could meet in confidence in the private interview rooms. Staff carried personal alarms whilst meeting with clients to keep safe. These were tested weekly.

Clinic rooms were well-equipped with the necessary equipment to carry out physical examinations. This included emergency equipment such as a defibrillator, resuscitation equipment and ligature cutters. Hepatitis B vaccines were administered in a separate blood borne virus (BBV) room and staff maintained equipment well and kept it clean in line with the provider's emergency medical equipment policy. There was also a separate non-medical prescriber (NMP) room for non-medical prescribers to use with clients. Daily checks were carried out on the equipment and medicines.

Maintenance, cleanliness and infection control

The premises were visibly clean during the time of our inspection. Staff completed an annual infection control audit. Staff adhered to infection control principles, including handwashing and the disposal of clinical waste. A cleaning audit was completed monthly.

The service completed an annual fire risk assessment which identified the key fire risks to the service and identified further works for improvement. For example, the service had experienced a flood which resulted in the need for extensive work to the fire doors within the building. At the time of our inspection, the work on the fire doors had been completed apart from one, which was due to be repaired. The allocated fire warden for the day was discussed in the daily handover meetings and the fire alarms were tested weekly.

Safe staffing

The service had enough staff, who knew the clients and received basic training to keep them safe from avoidable harm. The number of clients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each client the time they needed.

The staffing establishment levels were one operations manager, one service manager, one team leader, one doctor, 10 recovery support workers, including specialist roles, one building recovery in the community co-ordinator (BRIC), two non-medical prescribers, two administrators and three volunteer counsellors. All staff that we spoke with told us that their caseloads were manageable. At the time of our inspection, there were 269 clients accessing treatment.

The service had adequate cover arrangements for leave or vacant posts, to ensure that clients' needs were met. The service had a morning meeting to discuss staffing and cover arrangements for any unexpected sickness.

At the time of our inspection, there was one vacancy being covered by an agency staff worker. The staff sickness rate was 4.5%. There were six staff leavers in the previous 12 months. This was due to a change in service provider.

Staff were required to provide a disclosure barring system (DBS) certificate. This is a certificate to ensure that staff do not have any past history which may hinder from them in working with vulnerable adults. At the time of our inspection, the service was waiting for one DBS certificate to be processed. All clinical staff were expected to provide their professional registration personal identification number (PIN), which was checked and recorded periodically.

Mandatory training

Staff had received and were up to date with appropriate mandatory training. All staff had completed 98% of their mandatory training, which included fire safety awareness, mental capacity awareness and motivational interviewing training. Managers had checked that staff who had transferred from the previous provider were trained to deliver community detoxification and substitute prescribing safely.

Staff discussed any planned home visits in the daily handover meeting and always went in pairs to reduce the risk of harm occurring. However, there was a lone working policy if needed, which also covered staff working alone with clients within the building.

Assessing and managing risk to clients and staff

Staff kept detailed risk management records. Records were clear, up-to-date and easily available to all staff providing care.

During this inspection, we reviewed the risk management plans for five clients. Staff completed comprehensive risk management plans on admission that were reviewed regularly or when there was a change in risk. The risk management plans included any risks or potential risks such as substance misuse and driving, risks associated with mental health and any possible safeguarding concerns relating to children and families. Staff used this information to rate the level of risk for each client identifying the risks requiring action. The highest and unknown risks were rated red, less severe risks amber and the lowest risks were green as part of a traffic light system.

After the first assessment, all clients were placed in the red zone until they were discussed in the weekly multidisciplinary meeting (MDT) meeting and assigned to the most appropriate zone. Their zoning was reviewed weekly thereafter.

The service displayed leaflets reminding clients of their duty to inform the Driver and Vehicle Licensing Agency (DVLA) of any continued alcohol or drug misuse or dependence. If the client failed to disclose this information, they were advised that the doctor would have to break confidentiality and contact the DVLA on behalf of the client.

Management of patient/service user risk

Clients were made aware of the risks of continued substance misuse and safety planning was an integral part of recovery plans. Clients attended 12-weekly reviews to discuss their treatment and recovery plans.

Clients were expected to obtain medical summaries from their GP before engaging with the service. Staff were then expected to write to GPs to inform them of new clients who had accessed the service and any prescribed medicines. All clients who were prescribed medicines within the service were seen in person by the doctor or the non-medical prescriber (NMP). However, we could not see any correspondence to GPs in two of the five records for clients that had already accessed the service. This meant that we could not be assured that the GPs were aware of what medicines the two clients were on and this could have led to double prescribing (scripting) of medicines.

Staff identified and responded to changing risks to clients. We saw evidence in four of the five records that staff had considered and changed the risk rating where necessary. However, in one record there was no evidence that a liver function test was offered to a client who was assessed to have severe alcohol withdrawal symptoms. We also could not see that an appropriate treatment was recommended to the same client who tested as positive for Hepatitis C. This meant that we were not assured that all appropriate interventions had been offered to one client.

Clients that used substances on top of their medicines had an action plan in place to try and reduce this and were subject to supervised consumption. Staff also carried out random urine testing. This was to see if clients had used any illegal substances on top of their medicines. If clients presented with a positive urine sample, then they would be supervised whilst they took their medicines. The service had an agreement with seven local pharmacies to carry out supervised consumption with clients when required.

Clients could access advice in relation to smoking cessation, as the service had a smoking cessation lead.

Good

Community-based substance misuse services

During this inspection, we observed the daily morning meeting. Discussions included current client risks, safeguarding concerns, and any actions for staff to complete. Staff also discussed what blood borne virus (BBV) vaccinations and naloxone training had been completed with each client. Naloxone is used in an emergency to treat an overdose of narcotics.

The service had a clear procedure for staff to follow when clients began to disengage from the service or unexpectedly exited from their treatment. Staff were proactive in contacting clients who disengaged and by offered further appointments by telephone or letter or by conducting a home visit. Staff gave a recent example of becoming concerned about a client who had suddenly disengaged from the service and had decided with the service manager to conduct a welfare check at the client's home to ensure that they were safe.

The service had protocols in place for what to do when there were suspicions or evidence that clients had passed on their medicines to third parties.

Clients were expected to provide information about their next of kin or who to contact in an emergency.

Safeguarding

Staff understood how to protect clients from abuse and the service worked well with other agencies to do so. All staff had completed safeguarding adults and children level three training on how to recognise and report abuse, and they knew how to apply it.

The service had a dedicated safeguarding lead who had received level five safeguarding training. This meant that staff could access them for guidance and advice to keep clients safe. Posters were displayed in staff areas informing staff who the safeguarding leads were for the service, with photos and contact details.

Staff had access to an electronic safeguarding tracker, which kept track of children and adult safeguarding concerns raised with the local authority. This allowed staff to have oversight of any safeguarding referrals made and to chase any delays in responses. Staff were expected to follow up every day with the safeguarding team until they had received a response. The tracker was updated when there was a change in circumstance or a case review had taken place. Staff also attended a quarterly supervision session where they could review and reflect on any safeguarding cases they wished to discuss. Staff therefore had an opportunity to reflect on and discuss good practice in relation to safeguarding concerns.

The service worked closely with other services to ensure that clients were kept safe. This included working with the multi agency risk assessment conference (MARAC), which is a conference that discusses high risk domestic violence and abuse cases, and managers attended a local monthly safeguarding forum to ensure that relevant information was shared. Clients had access to an independent domestic violence advocate (IDVA) who visited weekly. An independent domestic violence advocate can provide advice and support to anyone that is experiencing domestic violence.

Managers ensured that the appropriate notifications were made to the Care Quality Commission in relation to safeguarding.

Staff access to essential information

Client information was stored on an electronic web-based case management system. Staff had prompt access to records.

Medicines management

Staff had effective policies, procedures and training related to medicine management including: prescribing, detoxification, assessing people's tolerance to medicines, and take-home medicines. Staff followed the Department of Health and Social Care's drug misuse and dependence UK guidelines on clinical management, also known as the 'Orange Book' to manage substitute prescribing and alcohol withdrawal.

The service had one full-time doctor. They were responsible for re-issuing prescriptions and administering medicines if required. Medical cover was discussed in the daily morning meeting. This was to ensure that clients who unexpectedly visited the service had prompt access to a doctor if needed.

The service also had two non-medical prescribers (NMPs) who could prescribe medicines in line with the service's policy. The service had a policy for titrating and associated treatment plans. Staff followed good practice in offering naloxone to clients who were subject to opiate substitute prescribing and at risk of overdosing. The service offered

naloxone kits to clients and staff trained clients on how to use them. The storage and issuing of naloxone was monitored and audited within the monthly clinical and medicine audits.

The service did not hold controlled drugs on site as these were dispensed through the local pharmacies.

Clients' medicines and recovery plans were reviewed every three months at medical reviews by the doctor or non-medical prescriber. This included safe medicines management. The service provided lockable boxes for clients to store their medicines at home. Staff visited clients who had children at home within 10 days of prescribing to ensure that medicines were being stored safely.

The service had a blood borne virus (BBV) clinic, which offered testing and vaccinations. The BBV nurse completed a checklist with clients to identify any risks which was then signed by the client before and after the staff administered any physical checks. The nurse then ensured that the GP was informed of the outcome with the client's consent.

Staff followed the service's policy in prescribing medicines and safe storage of prescription pads. Managers were responsible for ensuring that blank and completed prescription pads were stored securely. This was to reduce the risk of prescription pads being stolen and used to obtain medicines.

Track record on safety

The service had a good track record on safety. The service managed client safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave clients honest information and suitable support.

The service had recorded 20 serious incidents within the last 12 months. These related to client deaths and misuse of prescriptions and medicine errors. The service completed robust investigations as required.

Reporting incidents and learning from when things go wrong

Staff reported incidents on the incident reporting system within the service. Staff recorded incidents such as clients showing aggressive behaviour towards staff. The manager had oversight of all reported incidents and the reports were signed off by the governance team within WDP.

Staff were able to give us recent examples of learning from when things go wrong. For example, staff were now more alert to the veteran support services that could be accessed by people who had served in the armed forces. Staff discussed learning in the monthly information governance meetings.

Staff understood the duty of candour. They were open and transparent and gave clients and families using the service an explanation if something went wrong. Duty of candour is a legal requirement, which means providers must be open and transparent with clients about their care and treatment.

Are community-based substance misuse services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We examined five care and treatment records. Staff completed comprehensive assessments with clients new to the service in a timely manner. Assessments covered drug and alcohol history, safeguarding concerns including social needs, risks, mental health care needs and physical health needs including sexual health needs. Care and treatment records showed that staff met regularly with clients for one to one key working sessions.

Staff developed personalised recovery plans that met the needs identified in the client's assessment. Staff ensured that plans were made in conjunction with clients and were updated when there was a change in circumstances or presentation of risk. Staff developed a risk management plan for clients which included a plan for unexpected exit from treatment.

Clients were expected to attend a face to face assessment with the doctor within the service, followed by the non-medical prescriber, before being prescribed any medicines. This ensured that the client had an opportunity

to talk through their treatment plan and what to expect from any prescribed medicines. For example, clients receiving community detox were expected to have daily contact with the service and to be supported by an appropriate person within their home environment.

Staff supported clients to safely reduce and stop their alcohol and drug use through the appropriate use of withdrawal tools and by following national guidance on detoxification. Clients were also expected to attend pre-detoxification and post detoxification groups.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the client group. The interventions were those recommended by and were delivered in line with national guidance. The service followed Public Health England's guidance on working with substance misuse clients. The service provided interventions for stabilisation, reduction, withdrawal, community detoxification and relapse prevention. This included medication and psycho-social interventions, activities, training and work opportunities. They ensured that clients had good access to physical healthcare and supported clients to live healthier lives.

The service had a separate alcohol pathway which provided specific interventions for alcohol reduction and alcohol detoxification. For example, clients could attend an alcohol harm reduction group, this supported clients who drank harmfully to try and reduce this to safe levels by equipping them with the tools to do so, such as behaviour self-management.

Staff provided a range of psycho-social interventions to clients in addition to prescribing medicines. Clients could access one to one key working with their recovery worker, motivational interviewing, counselling, group work and the International Treatment Effectiveness Project (ITEP). The ITEP intervention aimed to improve treatment effectiveness. Clients were also offered a 12-step recovery programme called SMART. This helped clients to identify negative actions and thinking patterns that led to addictive behaviour. It then offered clients tools and techniques to support their recovery.

In four of the records there was no detailed recording of what psycho-social interventions were offered and what clients chose to access. For example, we could not see detailed recording of what was discussed in each key working session. However, we were assured that psycho-social interventions were being offered from talking to staff, clients and carers.

Clients were able to access groups such as separate male and female detoxification groups. During our inspection, we observed a women's preparation for detox group. Staff clearly explained the purpose and boundaries to all clients within the group. Staff provided clients with a preparation for detox checklist to complete and explained the process of a detoxification, both in the community and as an inpatient. This meant that staff provided information and reassured clients before they started the detoxification process.

Monitoring and comparing treatment outcomes

Staff reviewed care and recovery plans with clients every three months or when there was a change of circumstance, whichever was sooner. Four clients told us that staff had gone through their care and treatment plan with them.

Staff completed a Treatment Outcome Profile (TOP) with each client to measure the effectiveness of drug and alcohol treatment. Staff completed this at the start of the intervention with clients and at the end to compare the difference that the service had made to clients.

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of clients under their care. The service included a team of nurses, a doctor, non-medical prescribers, recovery practitioners, volunteer counsellors, administrators, managers and a building recovery in the community coordinator (BRIC).

Managers made sure that staff had the range of skills needed to support clients with substance misuse issues. The service had enrolled staff who had been transferred from a previous provider on to the recovery competency framework training. This included a bespoke recovery unit written by WDP that had been accredited by the Open College Network (OCN). This ensured that drug and alcohol practitioners within the service had received essential training to carry out their role in supporting clients to reduce their substance misuse. Staff also had additional training such as motivational interviewing, health coaching and one member of staff had completed a train the trainer course.

Good

Community-based substance misuse services

Managers provided monthly in-house learning workshops to staff. For example, the manager had recently completed a session with staff to identify what learning style works for them. Staff were also encouraged to think about what topics they would like to learn about. For example, one staff member had suggested de-escalation training.

Staff received monthly supervision, six weekly clinical supervision and other opportunities to update and further develop their skills. For example, two staff had enrolled on to the aspiring managers course and level five management training. Managers identified goals in annual appraisals and produced action plans for these to be completed during the year.

Managers provided a four-week induction programme for new staff. New staff were expected to read and understand the services' policies and procedures and complete their online mandatory training.

Some staff had transferred to the service when the provider changed. As part of the transfer, managers identified where staff required additional training or support to complete their roles and set performance targets for staff to complete.Managers addressed poor performance promptly and effectively.

At the time of our inspection, the service had three part-time volunteer counsellors, who were completing their British Association for Counselling and Psychotherapy (BACP) training.

Multi-disciplinary and inter-agency team work

The service had weekly multidisciplinary meetings. Staff ensured that there was multidisciplinary input into clients' comprehensive assessments, for example from community mental health teams, GPs, maternity services, children and family services, social workers and criminal justice services. A social worker attended the staff team meetings once a month to provide advice and guidance around the Care Act 2014.

Recovery plans demonstrated input from other stakeholders and had clear pathways to other support services, for example, housing support services.

The service had developed exceptional partnerships with other Merton services to ensure that the most effective pathways were in place for clients' care. Commissioners had acknowledged the beneficial relationships the service had formed with a variety of stakeholders within the wider community.

The service was working in partnership with WDP Kingston to run a peer mentoring training programme. At the time of our inspection, the service was working on recruiting peer mentors. Their role would be to provide support to clients who are going through treatment and explain the services that can be provided by WDP Merton.

The service requested a GP summary for each client before beginning any intervention and had built up a relationship with local GPs within Merton. One GP commented that since WDP Merton had provided the drug and alcohol service in Merton, there had been a marked improvement in engagement and communication with GPs.

The service had effective protocols in place for the shared care of clients who used their service. For example, the service had developed a partnership with the local acute hospital. They provided a weekly drop-in to the service to test and treat clients for Hepatitis C. A recovery practitioner provided a weekly alcohol liaison service at the local acute hospital. This enabled the service to offer fast track appointments to high risk clients who were in hospital and required prompt access to the service. The service worked together with the hospital team to produce aftercare plans for clients.

The service provided a criminal justice recovery practitioner who provided advice and outreach support to clients going through the criminal justice system. They also provided a weekly drop-in to a local magistrates' court.

The service provided a monthly drop-in to the local Young Men's Christian Association (YMCA) hostel. This ensured that any resident of the YMCA could access the service, including younger people.

The service discharged clients when specialist care was no longer necessary, and it worked with supporting services to ensure that relevant information was transferred. For example, care coordinators from the community mental health teams were invited to attend multidisciplinary meetings to discuss continuation of care.

Good practice in applying the MCA

Good

Community-based substance misuse services

Staff supported clients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2008 and knew what to do if a client's capacity to make decisions about their care might be impaired.

Staff had received training on the Mental Capacity Act and were aware of how substance misuse can affect capacity either on a permanent or a temporary basis. We examined five care records, these demonstrated good consideration of mental capacity and showed that staff followed the principles of mental capacity. The principles of the Mental Capacity Act were displayed throughout the service as a reminder.

Staff ensured that clients consented to their care and treatment and this was recorded and reviewed in a timely manner. Staff understood the importance of maintaining client confidentiality and obtaining consent from the client before sharing any information with third parties. Clients were expected to complete a consent form upon admission and consent was reviewed after individual key working sessions.

Are community-based substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

We spoke with four clients. All four clients informed us that they were treated with compassion, kindness, respect and their privacy was always maintained. During the inspection, we observed staff talking to clients in a caring and respectful manner.

We observed a group where staff provided all clients with an opportunity to speak and be listened to.

One client commented that staff were friendly, polite and helpful in creating a positive and healthy atmosphere. Another client said that the kindness and care was the best that they had ever received.

Staff supported clients to understand and manage their care, treatment and condition. During our inspection, we observed a preparation for detox group. Staff explained to clients as to what to expect when they started their detoxification journey. Clients could also attend an alcohol harm and awareness and reduction group. Recovery practitioners provided one to one key working session with clients to explain and manage their treatment and condition.

Involvement in care

Involvement of clients

Staff communicated with clients so that they understood their care and treatment, clients received information leaflets upon accessing the service and attended groups. All four clients we spoke with told us that staff helped them to understand their care and treatment plan.

Each client had a recovery plan and risk management plan in place that demonstrated their preferences and goals. All staff we spoke with told us that they actively involved clients in their recovery plan and this was reviewed with the client every three months. The service had developed information leaflets for clients to inform them of what to expect in relation to their care at treatment. For example, the service had a preparation for detox fact sheet.

Staff inducted new clients to the service with a registration pack. This included information on what the clients could expect from the service, for example how long treatment may take. Clients were expected to complete a diary of their alcohol or drug use before they were formally introduced into the service. This enabled clients to think about the extent of their drug or alcohol misuse and provided a benchmark to measure against. Clients were also invited to attend an induction group after their assessment. This introduced them to the treatment options and pathways and gave them the opportunity to ask questions.

Involvement of families and carers

Staff informed and involved families and carers when it was appropriate to do so. We spoke with three carers who confirmed that they were involved in the care and treatment of clients where appropriate. Clients were offered the opportunity to invite family members or carers to attend appointments with them.

The service had a weekly carers' forum facilitated by the counselling and families coordinator. This provided a space for carers to receive support for their own needs. One carer

told us that staff always listened and provided emotional support to them. This was also an opportunity for carers to feedback on the service that they or their family member had received.

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

Outstanding ☆

Access, waiting times and discharge

The service had robust alternative care pathways and referral systems in place for people whose needs could not be met by the service. The service had a very good working relationship with the local inpatient rehabilitation service for clients whose needs could not be met by WDP Merton.

Clients could access the service without delay as it did not have a waiting list. The service met the recommended national guidelines for assessing and beginning treatment within 15 days of a referral being made. Treatment was able to start after the necessary medical checks had been made. The service was able to prioritise urgent referrals and allocated these to a key worker in the daily handover meeting. The service offered quick appointments to clients who required this. Referrals were received from GPs, community mental health teams, social workers and other professionals, in addition to self-referrals. Staff ensured that alternative options were discussed with clients, if they were not able to comply with specific treatment requirements.

The service had robust processes in place for when clients arrived late or failed to attend their appointments. Clients who attended the groups late or severely intoxicated were asked to leave the group and return to another group when appropriate to do so. Clients who failed to attend their appointments and who presented as low risk were contacted with two further appointments before they were discharged from the service. There was robust follow up for high risk clients who failed to attend.

Discharges and transfers of care

The service went over and above to ensure that clients working towards discharge had the necessary support in place The service held a moving forward group, which was a 12-week programme that provided support for clients who were working towards being discharged from the service and reintegrating back into the community. Staff therefore ensured that clients were aware on how to access support from other services in the community. Clients also received monthly check ups from staff after they had been discharged to ensure that they were still following their recovery pathway.

The service was very proactive in listening to clients and making changes to improve discharge planning for clients. For example, clients had requested a more skills-based workshop on relapse prevention after discharge. The service had listened to this request and introduced a building recovery in the community group to equip clients with skills to prevent relapse in the community.

Staff were expected to discuss any planned discharges at the daily planning meeting or at the weekly multidisciplinary team meeting before discharging a client from the service. In addition, the service held a weekly discharge clinic. This was an opportunity for staff to discuss clients that were ready to be discharged from the service. This was also for staff to review what actions had been taken to re-engage any clients who had disengaged from the service. Staff followed an engagement plan to try and re-engage clients.

The service had clearly documented acceptance and referral criteria that had been agreed with stakeholders, including commissioners. Staff planned for clients' discharge. This included liaison with care coordinators and GPs and the service sent discharge summaries to all involved parties, with the client's consent.

Staff actively supported clients during transfers between services. For example, a recovery practitioner visited a client that had a period of admission at an acute hospital.

Facilities that promote comfort, dignity and privacy

The design, layout and furnishing of treatment rooms ensured that clients' treatment, privacy and dignity were respected. The service had enough interview rooms for key workers to meet with clients in private. The reception area had adequate seating for clients to use before meeting with their keyworker.

The service also had a television screen that displayed information about the services on offer for clients, carers

and families. For example, information was displayed about the blood borne virus vaccine (BBV) service. The service was also accessible for clients who had a physical disability.

Clients' engagement with the wider community

The service was exceptional in encouraging clients to access the local community and activities within it. The service had gone over and above in understanding the local community in Merton since taking over from the previous provider. The service had employed a building recovery in the community (BRIC) coordinator. They had been vital in building relationships with services in the local community. For example, the BRIC coordinator had recently delivered alcohol awareness training to a housing support service. They had also formed a partnership with a local community centre, to develop a drop-in service to homeless people within Merton. In addition, the service wanted to improve young people's access to the service, so the BRIC coordinator had established a drop-in service at the local YMCA.

Staff supported clients to maintain contact with their families and carers. Records showed that families and carers were involved when the client consented to this.

Staff were very proactive in ensuring that clients had access to education and work opportunities. Clients had the opportunity to access an employment support programme created by WDP called Giving Something Back (GSB). This offered focused training to clients to progress with their recovery to reintegrate back into work or into volunteering. Clients who were ready to access volunteering, could also access the WDP Nova project. This equipped clients with the skills and training to become a volunteer. Staff had also established a strong partnership with a local job centre, who provided monthly drop-ins at WDP Merton to provide advice and opportunities for clients to get back into employment. At the time of our inspection, the service had recruited two volunteers who were waiting for their Disclosure and Barring check to proceed with their role.

The service was innovative in creating a reward scheme to encourage clients, carers and families to engage with the service. This was called the capital card scheme . Clients could collect points on to a card by attending groups within the service. They could then spend the points with partners within the local community who had signed up with the scheme, this included local shops and restaurants. This meant that the service was rewarding client engagement through an earn and spend points system.

Meeting the needs of all people who use the service

Staff had a detailed understanding of the potential issues facing vulnerable groups, including lesbian, gay, bisexual and transgender plus (LGBT+) and those who had been subject to domestic abuse. The service had a specific information folder for LGBT+ clients who could access specific support for their needs. For example, information on chem-sex peer support groups in the local area. Clients had access to an independent domestic violence advocate (IDVA) who visited the service weekly.

Staff were exceptional in recognising and responding to the needs of the local population. For example, the service had recognised that there was a large Tamil population that required support with alcohol misuse. The service employed a Tamil speaking apprentice to provide specific group interventions in Tamil. The service had translated information leaflets about the service into Tamil and Polish, in recognition that some clients within the local community may not be able to speak and read English as a first language. Staff were also able to access a translation service for clients who required this for face to face appointments.

Staff provided information leaflets to clients about the different types of drugs and their side-effects, such as cannabis. The service also provided information around local services, which could aid service users in their recovery. For example, there was information on recovery cafés in the local area. The service had also produced an information folder within the reception area detailing local services that clients could access. Leaflets included information on local substance misuse support groups that clients could attend.

The service was flexible in meeting clients' needs. For example, the service recognised that clients may not feel comfortable attending groups with the opposite sex present, so offered separate male and female preparation for detox groups. The service also opened for two evenings a week in recognition that clients could not attend during the day if they had work or other commitments. Clients were also sent an automated reminder text with details of their next appointment through the services electronic

case management system. Home visits and medical reviews were offered to clients that were identified as being vulnerable, such as those who were recently discharged from hospital.

Staff actively encouraged clients to improve their own wellbeing. For example, clients could access a weekly acupuncture group, a yoga group and an art group.

At the time of this inspection, we saw a lack on explanation in the client information guide for alcohol detoxification around delirium tremens as a side effect when withdrawing from alcohol. However, staff reassured us that this was discussed in the preparation for detoxification group with clients. We also saw evidence that this was written in the preparation for detoxification leaflet given to clients before attending the group. We were therefore assured that clients were getting information surrounding delirium tremens but there was an inconsistency as to where this was mentioned in the written information.

All four clients told us that their treatment programme was consistent as group work and one to one sessions with key workers were rarely cancelled. Staff confirmed that they would cover sickness or unplanned absences within the team.

Listening to and learning from concerns and complaints

The service had a clear and effective complaints system and there was evidence of lessons being learnt and acted upon to improve the quality of the service.

The service had received eight formal complaints in the 12 months prior to the inspection. Seven complaints were upheld after the service had investigated them. Staff knew how to handle complaints appropriately in line with the service's complaints policy. We reviewed one complaint and found that the investigation and the response was appropriate and identified lessons to be learnt and discussed in the monthly information governance meeting. The complaint highlighted the need for staff to ascertain what level of support clients may require during the assessment process, as it could be a lengthy process. The service had also received 29 compliments within the last 12 months.

Three out of the four clients told us that they knew how to raise concerns or complain if they needed to. The service provided complaints and concerns leaflets in the reception area. There was also a feedback box in the reception area for clients, families and carers to suggest any ideas for improvement. Staff told us that they would try to resolve informal complaints with the client immediately or escalate these to the manager when necessary.

Are community-based substance misuse services well-led?

Good

Leadership

Leaders could clearly demonstrate that they had the skills, knowledge and experience to perform their roles. The service manager had over 13 years' experience of working in substance misuse services. Staff told us that leaders were visible in the service and approachable. The service manager worked on site and was in contact with staff throughout the day, including attending the daily planning meeting and multidisciplinary meetings. The operations manager also visited the service frequently.

Leaders had a thorough understanding of the services they managed. They could clearly explain how the team was working together to provide high quality care. The manager had introduced further training for staff after they had moved from a previous organisation to ensure that they worked to WDP's standards.

Vision and strategy

Staff knew and understood the vision and values of the team and wider organisation and their role in achieving that. The service had a local strategy map which linked the values of WDP centrally to the goals, mission, vision and delivery model of WDP Merton. The service values were being entrepreneurial, working in partnership, having a strong belief in service users and being community focused. Their mission was to support clients to identify their paths to goals and aspirations by offering a comprehensive menu of interventions. Staff had opportunities to contribute to developing the organisation and service strategies at team meetings, monthly information governance meetings and at the annual away day.

Staff we spoke with were able to clearly explain what positive recovery looked like and how this linked in with the

purpose of the organisation. For example, one staff member told us that positive recovery was when clients were supported holistically with all their needs, such as housing and physical health needs in addition to abstinence from drugs and alcohol.

Culture

All six staff we spoke with said that they felt respected, supported and valued by managers within the service. Staff spoke highly of the service manager and the operations manager and expressed that they felt positive and proud working within the team. Staff felt able to raise concerns with managers if they needed to.

Staff success was recognised through a WDP award scheme. The staff team within WDP Merton had recently won an award recognising that they had gone the extra mile within the service.

Staff could access support for their own physical and emotional health needs through an occupational health service provided by WDP. The service had also introduced a wellbeing hour, which encouraged staff to take time to focus in their wellbeing.

Managers were proactive in ensuring that staff appraisals addressed conversations about career development and set goals for staff. Staff were given an action plan with their identified goals to complete during the year. Staff could access development opportunities provided by WDP, this included aspiring managers courses and level five management training.

The staff team worked well together and where there were difficulties managers dealt with them appropriately.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities to staff who had experience of misusing substances.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively, and that performance and risk were managed well. Managers had effective oversight of systems and processes to ensure that the service was safe. The service had enough staff who were appropriately trained and supervised.

The provider had up-to-date policies and procedures to support staff to carry out their duties, including a prescription policy, records management retention policy, complaints policy, risk management policy, lone working policy, incident reporting policy and business continuity policy.

There was a clear framework of what was to be discussed at staff team meetings and monthly information governance meetings. We saw evidence that learning from incidents was discussed with the staff team in the monthly information governance meeting. This included recommendations from reviews of deaths, compliments and complaints. For example, a recent client death review report highlighted that staff could have offered to support the client to access veteran support services.

Staff undertook a range of clinical audits within WDP Merton, which identified areas which were working well and where the service needed to improve. These included infection control audits, safe storage of medicines audit and care plan audits.

The care plan audit identified areas of good practice, such as mental capacity being routinely considered in addition to areas of improvement. Shortcomings were addressed in an action plan for staff to complete, for example, through their supervision session. Audits provided assurance and staff acted upon the findings to improve the effectiveness of the service.

The service submitted data and appropriate notifications to external bodies when required, for example to the local authority safeguarding teams. Independent health providers are required to send statutory notifications to the Care Quality Commission (CQC), including safeguarding incidents and for a death of a service user. Safeguarding notifications were appropriately sent to the Care Quality Commission (CQC).

Management of risk, issues and performance

The service manager had access to the organisational risk register for WDP and was able to give examples of what was on the register specifically for WDP Merton. Risks included the potential for medicine errors and flooding.

The service had a business continuity plan, which addressed how to deal with emergencies, such as an IT failure or adverse weather conditions. The service had suffered from a flood earlier on in the year and had followed their business continuity plan, using other premises whilst this was resolved.

Good

Community-based substance misuse services

Information management

Staff ensured that incidents were recorded on the service's incident reporting system.

Staff informed us that they had the technology and equipment to do their work and the telephone system worked well. Clients told us that they did not face any problems in trying to phone staff when needed.

The service used an electronic confidential client record system. Managers had access to a dashboard which provided them with essential data on team performance and helped them to carry out their management roles. This included information on staffing and patient care. For example, managers were able to use the dashboard to monitor when clients had their last medical review. There was a separate dashboard to monitor supervision, training and sickness records.

Staff ensured that clients understood how their information was stored and shared and asked them to sign a consent form, which was kept in their client records.

Engagement

Staff, clients and carers had access to up-to-date information about the provider. The service produced a monthly newsletter which provided information on the services on offer as well as other informative advice for clients. For example, the November newsletter highlighted that it was alcohol awareness week within November and that there was due to be a new outreach project provided by WDP Merton.

Clients were able to give feedback about the service or suggest ideas for improvement in the monthly service user involvement forum. If clients chose not to attend the forum, they could provide suggestions in the feedback box placed in the reception area. The service displayed a 'you said, we did board' to show improvements that the service had made after listening to client feedback.

Managers ensured that clients were consulted when there was any change to the service. For example, clients were consulted as to how they wanted the environment to be re-decorated.

Carers and family members had an opportunity to feedback about the service through the monthly carers' forum.

Learning, continuous improvement and innovation

The service promoted continuous learning for all staff. The service manager provided regular workshops to staff to improve their skills and support their continuous professional development. For example, workshops were provided on communication skills, understanding different learning styles and emotional intelligence.

The service encouraged innovation and ensured that up to date evidence-based practice was implemented and embedded. The service had taken part in a fentanyl testing project with a local university. The service encouraged clients who had used opiates participate in testing to better understand the effects of fentanyl when mixed with opiates.

The service also had an expert patients programme, specific to this service. This was a programme for clients to learn the skills and tools for self-management of long-term health conditions.

The service participated in WDP's 'bright ideas' scheme, which rewarded staff who produced innovative ideas that could be implemented across WDP. This meant that the service encouraged innovation from staff to further develop the service.

Outstanding practice and areas for improvement

Outstanding practice

- The service was exceptional in encouraging clients to access the local community and activities within it. The service had formed a partnership with a local community centre, to develop a drop-in service to homeless people within Merton. In addition, the service wanted to improve young people's access to the service, so the BRIC coordinator had established a drop-in service at the local Young Men's Christian Association. (YMCA).
- The service had recognised that there was a large Tamil population that required support with alcohol misuse. The service employed a Tamil speaking apprentice to provide specific group interventions in Tamil. The service had translated information leaflets about the service into Tamil and Polish, in recognition that some clients within the local community may not be able to speak and read English as a first language.
- Clients had the opportunity to access an employment support programme created by WDP called Giving Something Back (GSB). Staff had established a partnership with a local job centre who provided monthly drop-ins at WDP Merton to provide advice and opportunities for clients to get back into employment.
- The service was innovative in creating a reward scheme to encourage clients, carers and families to engage with the service. This was called the capital card scheme. Clients could collect points on to a card by attending groups within the service. They could then spend the points with partners within the local community who had signed up with the scheme. This meant that the service was rewarding client engagement through an earn and spend points system.
- The staff team within WDP Merton had recently won an award recognising that they had gone the extra mile within the service.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that updated ways of working are fully embedded to ensure that relevant physical health screening is arranged for all clients and, if not, the rationale should be recorded.
- The provider should ensure that psycho-social interventions are more fully recorded in the care notes.