

# Central and North West London NHS Foundation Trust

## Substance misuse services

### Quality Report

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### Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RV3EE	Stephenson House	Community substance misuse services	Ealing Rise (W13 9BP) North Westminster (W9 3RU) Hillingdon (UB8 1JP) Brent (NW10 4UP)

This report describes our judgement of the quality of care provided within this core service by Central North West London NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Central North West London NHS Foundation Trust and these are brought together to inform our overall judgement of Central North West London NHS Foundation Trust.

# Summary of findings

## **Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards**

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

### **This service was not rated**

Suitable numbers of staff were employed at each site, with appropriate arrangements in place to cover vacant posts with regular staff, ensuring consistency of care and treatment. All of the services we visited valued the contribution of volunteers and peer support workers who had previously received treatment. At all sites, staff were engaged in partnership working, in line with current best practice. Staff received appropriate training, supervision and professional development. There was effective multi disciplinary team (MDT) working taking place. Each of the services we visited had developed good working links with partners and external agencies, such as GPs, social services and mental health services.

The premises that we visited were clean and free from clutter. Each had a suitably equipped clinical room. Appropriate arrangements were in place at each site to manage medicines and to dispose of sharps and clinical waste safely.

Initial patient assessments were completed in a timely manner and care and treatment was delivered in line with individual care plans. Overall, care plans were regularly reviewed and updated. The majority of patients were aware of their care plan and felt that they included their

views. A standardised patient risk assessment was in use. We found that across all sites where potential risks had been identified there was not always a management plan to address these.

Patients received regular medical reviews with a doctor employed by the service.

At the time of our inspection no waiting lists were in operation at the services we visited. Patients were initially assessed on the day that they attended the service. Each of the services was able to offer a rapid medication pathway. The services that we visited had arrangements in place to follow up with patients who disengaged. Patients we spoke with knew how to complain and staff we spoke with knew about the complaints procedure and how to deal with complaints appropriately.

We found each service to be well-led. There was evidence of clear leadership at a local level. The culture of each service was open and encouraged staff to bring forward ideas for improving care. Staff we spoke with also told us that they felt supported by their service managers and felt that there was two way communication from “the board to the ward”. Each service had access to systems of governance that enabled them to monitor the quality of service provision and a range of measures were in place to gauge the performance of each site.

# Summary of findings

## The five questions we ask about the service and what we found

### Are services safe?

The premises were clean and free from clutter. Each had a suitably equipped clinical room. Emergency medicines were available in each of the clinic rooms and these were checked regularly. Interview rooms were fitted with alarms. Appropriate arrangements were in place at each site to manage medicines and to dispose of sharps and clinical waste safely. We found that at the Hillingdon site some medical supplies had passed their expiry date and had not been disposed of.

Suitable numbers of staff were employed at each site, with appropriate arrangements in place to cover vacant posts with regular staff, thereby ensuring consistency of care and treatment. Arrangements were in place to recruit to vacant posts. Patients told us that they felt safe using services.

Each person who was seen by the service had an initial assessment completed. A standardised risk assessment tool was in use at each of the sites we visited. Each of the sites had completed a patient note audit; this identified that across services a risk assessment was not always being completed in the first three months of treatment. Action plans were in place to address this. We found that for patients undertaking a community based alcohol detoxification programme this was not always specifically risk assessed. We also found that where risks had been identified during initial assessment there was not always a management plan to address these.

Staff we spoke with had completed mandatory child and adult safeguarding training and were able to demonstrate an understanding of safeguarding issues appropriate to their role and responsibilities. Staff liaised appropriately with other agencies where safeguarding concerns were identified. We found that at each site appropriate regard was given during initial assessment to identify any potential adult or child safeguarding concerns relating to the patient.

Staff we spoke to at all sites knew how to recognise and report incidents. All incidents were reviewed by the service manager and forwarded to the trusts central governance team who maintained oversight. Staff were aware of learning from incidents through emails, bulletins and through staff meetings.

### Are services effective?

Initial assessments were completed in a timely manner and care and treatment was delivered in line with individual care plans.

# Summary of findings

Physical health checks were taking place, but the results of these were not always readily accessible as they were recorded in different places. Each of the services we visited offered blood borne virus clinics, where basic health checks were carried out.

Care plans were regularly reviewed and updated. The majority of care plans were personalised and were recovery orientated. We noted that for each site a different care plan format was used. At some sites the care plans produced were not holistic and did not contain all information relating to the persons treatment and care and did not include the patients views. Our discussions with patients evidenced that the majority were aware of their care plan and felt that they included their views.

National Institute for Health and Care Excellence (NICE) guidance was followed for prescribing medication, non-medical prescribing and the provision of psychosocial interventions, including motivational interviewing. At all sites, staff were engaged in partnership working, in line with current best practice. Staff received appropriate training, supervision and professional development.

Patients received regular medical reviews with a doctor employed by the service. However, we found that at the Hillingdon service staff were not clear how often patients being prescribed controlled medicines should be reviewed by the doctor. We found that where patients were being prescribed high doses of controlled medicines and were at risk of associated health conditions such as QT prolongation, they were usually appropriately monitored to address this, with the results of their ECG (heart tracing) made available to medical staff.

Staff employed by the trust came from a range of professional backgrounds including nursing, medical and psychological. There was effective multi disciplinary team working taking place. Each of the services we visited had developed good working links with partners and external agencies, such as GPs, social services and mental health services.

## Are services caring?

Patients told us that staff treated them with respect and were very professional and helpful. They also commented that the care and treatment they received met their needs. Staff interacted with patients in a caring and compassionate way. Staff appeared committed and engaged in providing good quality care to patients and during our discussions demonstrated a sound understanding of their needs.

# Summary of findings

Patients told us that they were aware of their care plans and that these were discussed with them during one to ones. Each of the services we visited had access to recovery capital services (access to housing, education and employment resources).

At the majority of services, recovery care plans were service user focused and contained goals identified by the person using the service. Advocacy services were available to patients. All of the services we visited valued the contribution of volunteers and peer supporters who had previously received treatment. We saw that peer supporters were appropriately involved in team discussions and that people who use services were represented on a range of planning and delivery boards across the various services.

## **Are services responsive to people's needs?**

At the time of our inspection no waiting lists were in operation at the services we visited, patients were initially assessed on the day that they attended the service. Each of the services was able to offer a rapid medication pathway, whereby patients could be commenced on a starting dose of medication within 3 days of initially attending the service.

Ealing and North Westminster services operated in partnerships where a “one stop shop” approach had been adopted. Patients could receive their treatment and support with social issues all in one place. Patients we spoke with valued this approach. Each of the services that we visited had arrangements in place to follow up with patients who disengaged with services.

Each of the services had shared care arrangements in place, which meant that primary responsibility for the care of some patients could be transferred back to their GP with specialist advice and support, allowing the service to take on new patients.

Patients were seen at all of the premises we visited. A full range of rooms for one to ones, group activities and clinical rooms were available. Clinical rooms were appropriately furnished and equipped to support treatment and care. At the North Westminster team some ongoing maintenance issues had been identified and the provider was taking steps to address these.

A range of information leaflets on treatments, local services, patients rights and how to complain were accessible in the reception area of each of the services we visited. Patients we spoke with knew how to complain. Staff we spoke with knew about the complaints procedure and how to deal with complaints appropriately. We

# Summary of findings

looked at complaints records and saw that complaints were recorded along with details of the investigation undertaken, its outcome and how this information was feedback to the complainant.

## **Are services well-led?**

We found each service to be well-led. There was evidence of clear leadership at a local level. The culture of each service was open and encouraged staff to bring forward ideas for improving care.

Staff were aware of the trust's values. Where services were provided in partnership staff had incorporated the trust's values into local partnership philosophies. Staff told us that they felt supported by their service managers and felt that there was two way communication from "the board to the ward". Service managers had regular contact with their line managers, and told us that they felt supported in their role.

Each service had access to systems of governance that enabled them to monitor the quality of service provision, for example access to electronic records to monitor training. Staff were regularly supervised and appraised, incidents were appropriately recorded and staff were involved in clinical audit. Staff learnt from incidents, complaints and patient feedback. Safeguarding procedures were followed.

Each service had a range of measures in place to gauge the performance of the team. These tools and the outcome of each measure were available in an accessible format, and were used by the team to develop action plans where issues were identified.

Each of the services we visited spoke of their pride at involving people who use services in service delivery and development. There was good practice and innovation at each of the sites we visited.



# Summary of findings

## Information about the service

Central and North West London NHS Foundation Trust provides a range of substance misuse services in the community. We visited services provided at Ealing Rise (99-103 The Broadway, W13 9BP), North Westminster Drug and Alcohol Service (474 Harrow Road, London, W9 3RU), Hillingdon Drug and Alcohol Service (64 High Street, UB8 1JP) and Brent Drug and Alcohol Service (27 Station Road, NW10 4UP). Some of these services were provided in partnership with other organisations.

We had previously inspected drug and alcohol services provided by the trust on one occasion, during an inspection on the 15th and 23rd May 2013. We found that services were compliant.

## Our inspection team

The team that inspected community substance misuse services consisted of five people: two experts by experience, one inspector two nurse specialist advisors.

The inspector and one specialist advisor visited a different community substance misuse team each day, and were joined on two occasions by an expert by experience.

## Why we carried out this inspection

We inspected this trust as part of our ongoing comprehensive mental health inspection programme.

## How we carried out this inspection

To get to the heart of 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 these services, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- Visited community substance teams based at Ealing, North Westminster, Hillingdon and Brent. We looked at how services were provided, the quality of the environment and observed how staff were caring for patients.
- Spoke with 23 patients who were using the service, or had used the service.
- Spoke with the service manager for each of the sites.
- Spoke with 28 other staff members; including doctors and nurses.

We also:

- Looked at 30 treatment records of patients.
- Carried out a specific check of the clinical room at each site.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

# Summary of findings

## What people who use the provider's services say

During the inspection we spoke with 23 patients. The majority were positive about their experience of care and treatment. They told us that services were responsive,

with no waiting lists and that staff treated them with respect and were very professional and helpful. Overall, patients we spoke with rated the service they received very highly.

## Good practice

We found good practice at all of the sites we visited. At Ealing the introduction of a hospital based Alcohol Care Team had led to a reduction in the number of admissions for alcohol related illness. At North Westminster the service was able to offer a range of onsite health checks including hepatology testing and fibrascans. The service at Hillingdon had won a trust award the previous year for team work, and was carrying out research on how best to re-engage with patients who left treatment early.

At all the sites we visited we found evidence of service user involvement in the planning and delivery of services at all levels. We also found that services at all of the sites we visited were very responsive, with the majority being able to offer an initial assessment on the day the patient first presented to the service. All of the services we visited were able to provide rapid access to treatment with medications, with these commencing within 3 days of the patients initial assessment.

## Areas for improvement

### Action the provider **SHOULD** take to improve

- The provider should ensure that each person receiving treatment has potential risks associated with the treatment assessed, and that where potential risks are identified an appropriate plan to manage or mitigate these risks is put in place. This work had been identified by the trust and needs to be completed.
- The provider should ensure that a robust system to monitor and dispose of medical equipment that has passed its expiry date is in place at each site.
- The provider must ensure that every patient with identified health risks, such as at QT prolongation, are referred at regular intervals for electrocardiograms (heart tracing), in line with trust policy and procedure.
- The provider should ensure that staff record information relating to physical health checks in a standardised format to ensure that this information is readily accessible to all staff who may need to access it.
- The provider should ensure that recovery care plans across all sites are holistic and contain all information relating to care and treatment including the views of the patient.
- The provider should ensure that a clear policy and procedure is available at all sites that provides guidance on the frequency with which patients prescribed controlled medicines should be reviewed by the prescribing doctor.
- The provider should ensure that premises promote the dignity of people needing to access facilities at each geographical site.

## Central and North West London NHS Foundation Trust

# Substance misuse services

### Detailed findings

#### Locations inspected

**Name of service (e.g. ward/unit/team)**

**Name of CQC registered location**

#### Mental Capacity Act and Deprivation of Liberty Safeguards

Training in the Mental Capacity Act (2005) was mandatory for all staff, and the training records we saw evidenced that the majority of staff had completed this. Staff we spoke with were aware of the MCA and some were able to describe situations where they had assessed a person's capacity.

Staff told us that patients' substance misuse may affect their capacity, and that if a patient attended for an appointment where decisions regarding their care and treatment were needed whilst intoxicated they would assess their capacity, and may ask them to return at a later date, and advise them that they should not be intoxicated at that time.

# Are services safe?

By safe, we mean that people are protected from abuse\* and avoidable harm

\* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

## Summary of findings

The premises were clean and free from clutter. Each had a suitably equipped clinical room. Emergency medicines were available in each of the clinic rooms and these were checked regularly. Interview rooms were fitted with alarms. Appropriate arrangements were in place at each site to manage medicines and to dispose of sharps and clinical waste safely. We found that at the Hillingdon site some medical supplies had passed their expiry date and had not been disposed of.

Suitable numbers of staff were employed at each site, with appropriate arrangements in place to cover vacant posts with regular staff, thereby ensuring consistency of care and treatment. Arrangements were in place to recruit to vacant posts. Patients told us that they felt safe using services.

Each person who was seen by the service had an initial assessment completed. A standardised risk assessment tool was in use at each of the sites we visited. Each of the sites had completed a patient note audit, this identified that across services a risk assessment was not always being completed in the first three months of treatment. Action plans were in place to address this. We found that for patients undertaking a community based alcohol detoxification programme this was not always specifically risk assessed. We also found that where risks had been identified during initial assessment there was not always a management plan to address these.

Staff we spoke with had completed mandatory child and adult safeguarding training and were able to demonstrate an understanding of safeguarding issues appropriate to their role and responsibilities. Staff liaised appropriately with other agencies where safeguarding concerns were identified. We found that at each site appropriate regard was given during initial assessment to identify any potential adult or child safeguarding concerns relating to the patient.

Staff we spoke to at all sites knew how to recognise and report incidents. All incidents were reviewed by the

service manager and forwarded to the trusts central governance team who maintained oversight. Staff were aware of learning from incidents through emails, bulletins and through staff meetings.

## Our findings

### Safe and clean environment

- The premises that we visited were clean and free from clutter. The premises occupied by the North Westminster Team were adequate. The provider had identified that some maintenance was required and action was in hand to address this. The Hillingdon Team premises did not allow patients to access the toilet without an escort, which compromised patient dignity. The premises occupied by the Brent Team did not allow disabled access, and the service manager told us that they would shortly be relocating to more suitable premises. The Ealing team had recently relocated to new premises which were of a high standard.
- We found that regular infection control audits were carried out, with action plans put in place to ensure that patients and staff were protected against the risks of infection. Needle exchanges were in operation at each of the sites that we visited, and we found that appropriate arrangements were in place for the disposal of these and other sharps as well as clinical waste.
- Each of the premises we visited had a suitably equipped clinical room, with the necessary equipment to carry out physical examinations. Emergency medicines were available in each of the clinic rooms and these were checked regularly. Most staff had received training in basic life support techniques.
- Interview rooms were fitted with alarms

### Safe staffing

- The trust had established the numbers of staff required at each site. We spoke with the service manager at each site, and established that a full staffing complement was in place at Ealing.

# Are services safe?

By safe, we mean that people are protected from abuse\* and avoidable harm

- At North Westminster there were two staff vacancies, these were both covered by regular agency staff to provide consistency of care and the trust had recruited permanent staff to these posts who were due to start.
- At Hillingdon a recent reconfiguration in the service had resulted in the reduction of some posts. At the time of our inspection there were vacancies for one band five nurse and a half time support worker that were not being covered by temporary staff. The service manager advised that they were in the process of tendering for the service and would review the staffing complement if this was awarded. We were advised that in the interim staff were absorbing additional duties to cover the vacant posts. Staff at Hillingdon we spoke with commented that they felt under pressure, but were managing. The service manager told us that caseloads were at their maximum, and that they would consider introducing a waiting list should demand for the service continue to rise.
- At Brent there were two staff vacancies, both of which were being covered by long term agency staff. A part time medical post was being covered by a locum doctor. The service manager advised that the contract for services had recently been renewed, and that the vacant posts would be recruited to.
- Staff and patients we spoke with told us that there sufficient staff to provide services, and that they were able to readily access a doctor at each site when needed.
- We looked at sample of patient records at each of the sites we visited. We found that at Ealing, a risk assessment was available for each of the patients whose records we looked at. However, we noted that where patients underwent an alcohol detoxification programme within their own home a specific risk assessment to address this had not been completed.
- At North Westminster, Hillingdon and Brent we found that a risk assessment had been completed for all but one patient (who was receiving a service in Brent) whose records we looked at. However, we found that where risks had been identified for patients over these sites (for example where previous incidents of self harm had been identified), there was no clear plan for how the potential risk would be managed or mitigated.
- Staff we spoke with had completed mandatory child and adult safeguarding training and were able to demonstrate an understanding of safeguarding issues appropriate to their role and responsibilities. Staff we spoke with were able to give examples of safeguarding concerns they had been involved with, both when raising this as a new concern and when providing treatment to a patient where safeguarding concerns had been previously identified.
- Some sites (for example Ealing) had developed a central log with a summary of safeguarding concerns and professional contacts that all staff could readily access should they be dealing with an unfamiliar patient on a duty basis. Other services (for example Brent) had developed a safeguarding tracker that showed all safeguarding referrals that had been made and the current situation or action with the referral.
- At each of the sites we visited we found evidence that staff liaised appropriately with other agencies where safeguarding concerns were identified and attended child or adult safeguarding meetings when requested. We also found that at each site appropriate regard was given during initial assessment to identify any potential adult or child safeguarding concerns relating to the patient.
- Patients were seen by staff at each of the sites we visited. Each service had developed protocols should patients need to be visited at home, and best practice was that this should be done with another professional.

## Assessing and managing risk to patients and staff

- We spoke with patients at all the sites we visited. People told us that they felt safe on the premises and would feel comfortable talking to staff if they were concerned about anything.
- A standardised risk assessment tool was in use at each of the sites we visited. Every person who was seen by the service had an initial assessment completed.
- Each of the sites we visited had completed a patient notes audit. This identified that across services a risk assessment was not always being completed in the first three months of treatment, and that in some instances the care plan was not linked to the risk assessment. Each of the services we visited had an action plan in place to address this issue.

# Are services safe?

By safe, we mean that people are protected from abuse\* and avoidable harm

- No controlled medicines were kept at any of the premises that we visited. Some medicines such as vaccines were available. We found that these were appropriately stored and monitored to ensure that they were used or disposed of prior to their expiry.
- Each site that we visited had appropriate arrangements in place to commence patients safely on prescribed medicines (titration). Each site that we visited also had appropriate arrangements in place with local pharmacies to be able to offer supervised consumption of controlled medicines for an appropriate period of time dependant upon individual circumstances and in line with best practice guidance.
- We found that at one site (Hillingdon) some medical supplies had passed their expiry date and had not been disposed of. We brought this to the attention of staff who disposed of the items during our visit and advised us that they would revise their monitoring system to ensure that all equipment kept in clinical rooms would be checked for expiry dates and disposed of appropriately when due.

## Track record on safety

- There had been no serious untoward incidents within this core service. Each of the sites we visited maintained a record of incidents that were recorded electronically, with service managers holding a central record of these, thereby maintaining oversight.

## Reporting incidents and learning from when things go wrong

- Staff we spoke with at all sites knew how to recognise and report incidents. All incidents were reviewed by the service manager and forwarded to the trusts central governance team who maintained oversight. The system ensured that senior managers within the trust were alerted to incidents promptly and could monitor the investigation and response to these.
- Incidents were investigated and some managers told us that they were made aware of incidents in other parts of the trust through governance meetings and weekly bulletins.

Staff we spoke to told us that they were kept aware of learning from incidents through emails, bulletins and through staff meetings. Staff we spoke with were able to give us examples of learning from incidents and describe how practice had changed as a result. Staff also told us that where serious incidents had occurred in the past they had been provided with support.

# Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

## Summary of findings

Initial assessments were completed in a timely manner and care and treatment was delivered in line with individual care plans. Physical health checks were taking place, but the results of these were not always readily accessible as they were recorded in different places. Each of the services we visited offered blood borne virus clinics, where basic health checks were carried out.

Care plans were regularly reviewed and updated. The majority of care plans were personalised and were recovery orientated. We noted that for each site a different care plan format was used. At some sites the care plans produced were not holistic and did not contain all information relating to the persons treatment and care and did not include the patients views. Our discussions with patients evidenced that the majority were aware of their care plan and felt that they included their views.

National Institute for Health and Care Excellence (NICE) guidance was followed for prescribing medication, non-medical prescribing and the provision of psychosocial interventions, including motivational interviewing. At all sites, staff were engaged in partnership working, in line with current best practice. Staff received appropriate training, supervision and professional development.

Patients received regular medical reviews with a doctor employed by the service. However, we found that at the Hillingdon service staff were not clear how often patients being prescribed controlled medicines should be reviewed by the doctor. We found that where patients were being prescribed high doses of controlled medicines and were at risk of associated health conditions such as QT prolongation, they were usually appropriately monitored to address this, with the results of their ECG (heart tracing) made available to medical staff.

Staff employed by the trust came from a range of professional backgrounds including nursing, medical and psychological. There was effective multi disciplinary

team working taking place. Each of the services we visited had developed good working links with partners and external agencies, such as GPs, social services and mental health services.

## Our findings

### Assessment of needs and planning of care

- We found that at each site initial assessments were completed in a timely manner and care was delivered in line with individual care plans. We found that physical health checks were taking place, but that the results of these were not always readily accessible as they could be recorded in several places within the patient's paper and electronic records.
- Each of the services we visited offered blood borne virus clinics, where basic health checks could be carried out and advice, testing and vaccination offered with regard to a range of conditions. Where prescribed medications were being self administered via injection staff were able to observe patients injecting practice and offer guidance. Appropriate needle exchange facilities were available at each of the sites we visited.
- We found that overall, care plans were regularly reviewed and updated. We found that the majority of care plans were personalised and were recovery orientated. We noted that for each site a different care plan format was used. At some sites, for example Ealing we noted that the care plans produced were not holistic and did not contain all information relating to the persons treatment and care. The progress notes that we saw and our discussions with patients and staff evidenced that staff at all sites did understand patient's needs and were able to meet them.
- The majority of patients we spoke to were aware of their care plan and felt that these included their views. We noted that in Brent, four people whose care records we looked at evidenced that their care plan was not personalised and did not include their views.

### Best practice in treatment and care

- NICE guidance was followed for prescribing medication. Drug misuse and dependence: UK guidelines for clinical management were being followed with regard to the



# Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

psychosocial interventions being provided to patients. A range of individual and group therapy was available for patients at each site, some of which had been developed to meet the needs of minority ethnic communities, for example an Asian family therapy service.

- At some locations, for example North Westminster, group work programmes were available at evenings and weekends. Psychologists and psychology assistants were part of the multi disciplinary team at each site we visited.
- Nursing staff were trained in motivational interviewing and were able to utilise this technique during their one to ones with patients. At some sites, for example Ealing, a recovery café located nearby the service was run by service users and provided peer support to patients.
- At a number of sites, non medical prescribers were included in the staffing complement and appropriate arrangements addressing clinical governance and supervision for non medical prescribers were in place.
- Shared care arrangements were in place at all of the services we visited which promoted equality of access for patients to primary care services and provided specialist advice to GPs on the treatment of patients with substance misuse issues.
- We found that where patients were being prescribed high doses of controlled medicines and were at risk of associated health conditions such as QT prolongation, they were generally appropriately monitored for this, with the results of their ECG (heart tracing) made available to medical staff. We did however note that for one patient receiving a service in North Westminster an ECG had not been completed every six months in line with their care plan and the services policy and procedure. We brought this to the attention of staff who advised that a medical review had been booked and an ECG would be requested.
- We found that overall patients received regular medical reviews with a doctor employed by the service. However, we found that at Hillingdon staff were not clear how often patients being prescribed controlled medicines should be reviewed by the doctor. We brought

this to the attention of the service manager, and were subsequently sent a copy of a local policy and procedure that had been developed and circulated to staff.

- A range of clinical audits were regularly undertaken by staff including review of patients care records, infection control and prescribing medicines. Action plans to address issues identified through audit were in place where required.

## Skilled staff to deliver care

- Staff employed by the trust to work across the sites came from a range of professional backgrounds including nursing, medical and psychological. At all sites, staff were engaged in partnership working with other specialist agencies, in line with current best practice.
- Staff received appropriate training, supervision and professional development. Staff told us that they had undertaken training relevant to their role including fire training, emergency life support, conflict resolution, physical interventions, safeguarding children, safeguarding adults, infection control and health and safety. Records showed that the majority of staff were up to date with their training. Service managers and line managers had access to electronic staff records. This allowed them to oversee progress in staff completing their training programme. The training helped to ensure that staff were able to deliver care to people safely and to an appropriate standard.
- Some staff at some sites (for example Hillingdon) told us that they had recently transferred to the service, and told us that they had received an appropriate induction.
- Staff told us that they received supervision every four to six weeks, where they were able to reflect on their practice. Staff also commented that they received an annual appraisal.

There were a variety of meetings within services that staff could attend, such as group supervision or reflective practice and business meetings. Many of the staff we spoke with mentioned good team work as one of the best things about their job.



# Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

## Multi-disciplinary and inter-agency team work

- Our discussions with staff and examination of patient records showed that there was effective MDT working taking place. Progress notes evidenced that advice and input from different professionals was sought. Patients we spoke with confirmed that they were supported by a number of different professionals within the team.
- Regular MDT meetings were evidenced as taking place. Staff we spoke with told us that when working in partnership these relationships were effective and supported the provision of care and treatment to patients.
- Each of the services we visited had developed good working links with external agencies, such as GPs, social services and mental health services. We saw evidence on patient notes that GPs were kept up to date with the treatment being provided by the service. Some services

had developed links with local mental health services and representatives regularly attended team meetings to discuss case management where a dual diagnosis had been made.

## Good practice in applying the Mental Capacity Act

- Training in the Mental Capacity Act (2005) was mandatory for all staff, and the training records we saw evidenced that the majority of staff had completed this. Staff we spoke with were aware of the MCA and some were able to describe situations where they had assessed a person's capacity.
- Staff told us that patients' substance misuse may affect their capacity, and that if a patient attended for an appointment where decisions regarding their care and treatment were needed whilst intoxicated they would assess their capacity, and may ask them to return at a later date, and advise them that they should not be intoxicated at that time.

# Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

## Summary of findings

Patients told us that staff treated them with respect and were very professional and helpful. They also commented that the care and treatment they received met their needs. Staff interacted with patients in a caring and compassionate way. Staff appeared committed and engaged in providing good quality care to patients and during our discussions demonstrated a sound understanding of their needs.

Patients told us that they were aware of their care plans and that these were discussed with them during one to ones. Each of the services we visited had access to recovery capital services (access to housing, education and employment resources).

At the majority of services, recovery care plans were service user focused and contained goals identified by the person using the service. Advocacy services were available to patients. All of the services we visited valued the contribution of volunteers and peer supporters who had previously received treatment. We saw that peer supporters were appropriately involved in team discussions and that people who use services were represented on a range of planning and delivery boards across the various services.

## Our findings

### Kindness, dignity, respect and support

- Patients told us that staff treated them with respect and were very professional and helpful. They also commented that they felt that the care and treatment they received met their needs.
- We observed staff interacting with patients in a caring and compassionate way. Staff responded to people in distress in a calm and respectful manner. At one site we observed staff de-escalate a situation in the waiting area by listening and speaking quietly to people who were frustrated or angry. Staff appeared committed and engaged in providing good quality care to patients.
- When staff spoke to us about patients, they discussed them in a respectful manner and showed a good understanding of their individual needs.

### The involvement of people in the care that they receive

- Differing care plan formats were in use across the four services we visited. We found that all of the patients whose records we looked at included a recovery care plan. Patients were offered copies of their care plans. Patients told us that they were aware of their care plans and that these were discussed with them during one to ones.
- Each of the services we visited had access to recovery capital services (access to housing, education and employment) that were provided in partnership.
- At all of the services we visited a range of information leaflets were available that gave patients information about the therapies available, and the medicines they might be prescribed. Staff told us that they gave patients information leaflets to take away to support discussions that had taken place with them and patients confirmed this when we spoke with them. Patients told us that they had been given appropriate information about medicines they had been prescribed to enable them to make an informed decision about their treatment.
- At some services recovery care plans were very service user focused and contained goals identified by the person using the service. At other services (for example Brent) we found that some recovery care plans did not contain the patients' views.
- Patients and staff told us that advocacy services could be provided through the trust patient advice liaison service or through peer supporters.
- All of the services we visited valued the contribution of volunteers and peer supporters who had previously received treatment. We saw that peer supporters were appropriately involved in team discussions and that service users were represented on a range of planning and delivery boards across the various services.
- At each of the services we visited, there was evidence that care planning addressed early exit from the service, and strategies to re-engage patients.

# Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

## Summary of findings

At the time of our inspection no waiting lists were in operation at the services we visited, patients were initially assessed on the day that they attended the service. Each of the services was able to offer a rapid medication pathway, whereby patients could be commenced on a starting dose of medication within 3 days of initially attending the service.

Ealing and North Westminster services operated in partnerships where a “one stop shop” approach had been adopted. Patients could receive their treatment and support with social issues all in one place. Patients we spoke with valued this approach. Each of the services that we visited had arrangements in place to follow up with patients who disengaged with services.

Each of the services had shared care arrangements in place, which meant that primary responsibility for the care of some patients could be transferred back to their GP with specialist advice and support, allowing the service to take on new patients.

Patients were seen at all of the premises we visited. A full range of rooms for one to ones, group activities and clinical rooms were available. Clinical rooms were appropriately furnished and equipped to support treatment and care. At the North Westminster team some ongoing maintenance issues had been identified and the provider was taking steps to address these.

A range of information leaflets on treatments, local services, patients rights and how to complain were accessible in the reception area of each of the services we visited. Patients we spoke with knew how to complain. Staff we spoke with knew about the complaints procedure and how to deal with complaints appropriately. We looked at complaints records and saw that complaints were recorded along with details of the investigation undertaken, its outcome and how this information was feedback to the complainant.

## Our findings

### Access and discharge

- Each of the services had a target that patients referred to the service would be seen within three weeks. At the time of our inspection no waiting lists were in operation at any service, and patients were initially assessed on the day that they attended the service. One service manager (Hillingdon) advised that due to the high numbers of patients attending for initial assessments with the duty worker they may need to consider operating a waiting list system in the future.
- Each of the services we visited was able to offer a rapid medication pathway, whereby patients could be commenced on a starting dose of medications (titration) within 3 days of initially attending at the service. Patients and staff we spoke with confirmed that they would be reviewed frequently (initially on a daily basis) until the optimum dose of medication was reached. During the titration process a withdrawal assessment tool, urine drug screens, physical examination and observations and discussions with the patient were used to establish the starting dose of medication.
- Patients we spoke with told us that when they contacted the service outside of scheduled contacts they were always able to speak to a member of staff who was able to provide them with appropriate support or information.
- Some services, for example Hillingdon, did have criteria that patients would need to meet before being offered a service. Where people did not meet the threshold for eligibility the service had good partnership arrangements in place and could refer patients on to an appropriate service. The particular service patients could be referred onto was located in the same building, which meant that patients could readily make contact.
- Ealing and North Westminster services operated in partnerships where a “one stop shop” approach had been adopted, and patients could receive their treatment and support with social issues all in one place. Patients we spoke with valued this approach.
- Each of the services that we visited had arrangements in place to follow up with patients who disengaged with services. At Hillingdon, this took the form of an identified

# Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

“engagement pathway” where a formal process to follow up on patients missing appointments was adopted. At other services staff worked with outreach workers to re-establish contact with people who were not attending for appointments.

- Each of the services that we visited had shared care arrangements in place, which meant that primary responsibility for the care of some patients was transferred back to their GP with specialist advice and support, allowing the service to take on new patients.
- Patients we spoke with told us that there was flexibility in the appointment times that were offered, and that appointments were only rarely cancelled. They also commented that appointments ran on time, and that they were kept informed when there might be delays.
- Patients and staff at Hillingdon commented that daily duty appointments were often over subscribed, and some patients expressed their frustration at having to return for a second day to try and access a duty appointment. The service manager told us that they were considering operating a waiting list for duty appointments to combat this issue.

## **The facilities promote recovery, comfort, dignity and confidentiality**

- Patients were seen at all of the premises we visited. Services based in Ealing had recently relocated to new premises that were clean, well maintained and had good furnishings. Services based in Brent were due to relocate to new premises shortly after our inspection. Services in North Westminster and Hillingdon were operating from premises that were not purpose built and had been adapted for use. At Hillingdon, we noted that reception staff sat behind a glazed partition, and some patients commented that this felt uncomfortable for them. We noted that patients at this service did not

have access to a toilet in the reception area, and had to be escorted which did not promote dignity or respect. At the North Westminster premises several maintenance issues had been identified by the provider and our discussions with staff and review of maintenance records evidenced that the service was taking appropriate steps to address maintenance issues, most notably problems with damp in basement offices used by staff, and a malodorous smell.

- A full range of rooms for one to ones, group activities and clinical rooms were available at each of the sites we visited. Clinical rooms were appropriately furnished and equipped to support treatment and care.

## **Meeting the needs of all people who use the service**

- A range of information leaflets on treatments, local services, patients' rights and how to complain were accessible in the reception area of each of the services we visited.

## **Listening to and learning from concerns and complaints**

- Patients we spoke with knew how to complain. Nobody we spoke with had had reason to make a complaint. Each of the service managers we talked with held information locally on complaints that had been made. We looked at this information and saw that complaints were recorded along with details of the investigation undertaken, its outcome and details of how the outcome was feedback to complainants.
- Staff we spoke with knew about the services complaints procedure and how to deal with complaints appropriately. Service managers told us that learning from complaints was shared with the team at meetings.

# Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

## Summary of findings

We found each service to be well-led. There was evidence of clear leadership at a local level. The culture of each service was open and encouraged staff to bring forward ideas for improving care.

Staff were aware of the trust's values. Where services were provided in partnership staff had incorporated the trusts values into local partnership philosophies. Staff told us that they felt supported by their service managers and felt that there was two way communication from "the board to the ward". Service managers had regular contact with their line managers, and told us that they felt supported in their role.

Each service had access to systems of governance that enabled them to monitor the quality of service provision, for example access to electronic records to monitor training. Staff were regularly supervised and appraised, incidents were appropriately recorded and staff were involved in clinical audit. Staff learnt from incidents, complaints and patient feedback. Safeguarding procedures were followed.

Each service had a range of measures in place to gauge the performance of the team. These tools and the outcome of each measure were available in an accessible format, and were used by the team to develop action plans where issues were identified.

Each of the services we visited spoke of their pride at involving people who use services in service delivery and development. There was good practice and innovation at each of the sites we visited.

## Our findings

### Vision and values

- Staff were aware of the trust's values. Where services were provided in partnership staff had incorporated the trust's values into local partnership philosophies.
- Staff told us that they felt supported by their service managers and felt that there was two communication from "the board to the ward".

- Service managers had regular contact with their line managers, and said that they felt supported in their role

### Good governance

- Each service had access to systems of governance that enabled them to monitor the quality of service provision, for example access to electronic records to monitor training. Staff were regularly supervised and appraised, and maximised time on duty in direct care activities. Incidents were appropriately recorded and staff were involved in clinical audit. Staff learnt from incidents, complaints and patient feedback.
- Each service had a range of measures in place to gauge the performance of the team. We were shown tools that indicated the numbers of patients seen, the outcome of their treatment and how this measured against targets for each team. In some areas where targets had not been met this was highlighted and action plans were in place to improve performance.
- Service managers told us that they had enough time and autonomy to manage the service. They also said that where they had concerns, they could raise them. Where appropriate the concerns could be placed on the trusts risk register.

### Leadership, morale and staff engagement

- We found each service to be well-led. There was evidence of clear leadership at a local level. Service managers were visible on site during the provision of care and treatment, they were accessible to staff and they were proactive in providing support. The culture of each service was open and encouraged staff to bring forward ideas for improving care.
- Staff we spoke with were enthusiastic and engaged with developments in each individual service. They told us they felt able to report incidents, raise concerns and make suggestions. They were confident they would be listened to by their line manager.
- Sickness rates were low in the services that we visited. One member of staff at one service was on long term sick, and their service manager advised that they were planning a phased return to work.
- At the time of our inspection there were no disciplinary procedures being pursued in any of the services, and there were no allegations of bullying or harassment.

# Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- Staff were aware of the whistleblowing process if they needed to use it.

## **Commitment to quality improvement and innovation**

- Each of the services we visited spoke of their pride at involving people who use services in service delivery and development. We saw evidence of patient involvement in the delivery and planning of services at all levels of each service.
- We found specific evidence of good practice and innovation at each of the sites we visited. For example at

Ealing the introduction of a hospital based alcohol care team as part of the service had led to a reduction in the number of admissions to hospital for alcohol related illness. At North Westminster onsite medical facilities to provide hepatology services and fibroscans were regularly available, which meant that people needing to access these services could do so on site. At Hillingdon research was underway regarding the engagement pathway for patients who disengaged services before completion of their treatment. This team had also been awarded by the trust for its achievements in team working.