WDP Havering

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?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

Overall summary

We rated WDP Havering as good because:

- The service provided safe, effective and high quality care. Staff consistently followed best practice concerning clients' substance misuse treatment.
- There were monthly staff meetings focused on discussing clients with safeguarding risks. The safeguarding lead had undertaken audits, resulting in staff consistently undertaking a home visit for clients with young children to assess the safe storage of prescribed medicines. The process for monitoring and auditing safeguarding referrals and actions enhanced the safety of clients and others.
- The outcome of a mortality review was fed back to the local authority commissioners and the local public health team concerning the increase in older adults using the service. Managers were working with partners to identify ways to enhance clients' care, including end of life care.
- Managers had recognised that clients' access to Improving Access to Psychological Therapies was dependant on them being abstinent from substances for three months. They had arranged for a worker from that service to attend the service two days per week. If a client was in treatment at the service the three-month rule was waived.
- Leaders in the service had high levels of experience, capacity and capability to deliver high quality treatment and care. They provided compassionate, effective and inclusive leadership of the service and had developed a culture of openness, transparency and continuous improvement.
- The views of clients and families and carers were viewed as essential to the operation of, and developments in, the service. Groups for clients and families and carers were open and leaders in the service welcomed constructive challenge. Decisions regarding the service were made transparently with clients. If a new idea could not be developed, there was an explanation, and encouragement to identify an alternative.
- Individual staff members and service user representatives were the joint leads for specific areas of the service. They worked collaboratively to problem-solve and develop the service in those areas. This included areas not usually associated with client involvement, such as safeguarding.
- Staff described a respectful, supportive culture where they felt valued and motivated to provide high quality care and treatment. Staff were empowered to carry out their roles and there was a strong focus on career development. Staff were very positive concerning the leadership team and were proud to work for the provider.
- The service had an integrated governance system which provided effective and accurate monitoring and assurance of risks, issues and performance in the service. There were governance processes for all areas of practice. Leaders addressed areas for improvement with staff quickly and effectively.
- Leaders worked systematically, proactively and effectively with partners. The service led on identifying changes in the local population who misused substances and identifying areas of unmet need. This had included access to psychological therapies, the homeless population and the increasing number of older adult clients.
- Staff had access to the information they needed to provide safe and effective care and used that information to good effect. Managers had accurate information to monitor the performance of the service. There was a comprehensive governance system.

However:

- Although all clients' risk assessments documented potential risks, the full context of those risk was not always described. Leaders had identified this and there were plans to hold workshops after the inspection.
- A minority of clients' care plans were generic. Whilst they addressed clients' needs, they were not personalised or holistic. This had been identified and workshops were due to take place.

Summary of findings

Contents

Good

WDP Havering

Services we looked at

Community-based substance misuse services

Summary of this inspection

Background to WDP Havering

WDP Havering provides a drug and alcohol service for adults in the London Borough of Havering. The service provides information and advice, substitute prescribing, community detoxification, blood borne virus screening and vaccination, a group programme and psychosocial interventions. WDP Havering have been operating the service since 2015.

The service had 583 clients on their caseload at the time of the inspection. The service was provided at the registered address and at the recovery hub which was located in the same street. The service was open weekdays, including two evenings until 8.30pm. The service was also open on Saturday mornings.

The service is registered to provide the regulated activity of treatment of disease, disorder or injury.

There was a registered manager in post at the time of the inspection.

We have inspected WDP Havering once. Our last inspection was in November 2016. We did not rate independent substance misuse services at that time.

Following that inspection we issued three requirement notices concerning the following regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

Regulation 12 – safe care and treatment

Regulation 17 – good governance

Regulation 18 – staffing

The requirement notices concerned poor risk assessments of clients, lack of contact with clients' GPs, poor management of medicines and prescriptions for controlled drugs, a lack of staff, lack of supervision of staff, staff not undertaking mandatory training, and no effective system for learning from incidents or dealing with complaints. These matters were resolved at this inspection.

Our inspection team

The team that inspected WDP Havering consisted of two CQC Inspectors and a CQC specialist advisor, who is a consultant psychiatrist with experience working in substance misuse services.

Why we carried out this inspection

We inspected this service as part of our comprehensive 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:

Summary of this inspection

- visited the service, looked at the quality of the environment and observed how staff were caring for clients;
- spoke with five clients who were using the service;
- spoke with the family member of a client using the service;
- spoke with three peer mentors for the service;
- spoke with the registered manager;
- spoke with 11 other staff members; including a doctor, team leaders, registered nurses, practitioners, a student social worker, a receptionist and an administrator
- spoke with the provider's medical director and head of quality and compliance;
- attended and observed a morning multi-disciplinary meeting;
- looked at nine care and treatment records of clients of the service; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

All of the clients spoke very highly of staff in the service. They described being fully involved in their care and treatment and of developing strong therapeutic relationships with staff. They found staff supportive and able to provide practical and emotional assistance.

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:

- The premises where clients received care were safe, clean, well equipped, well furnished and well maintained.
- 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.
- Staff assessed and managed risks to clients and themselves. They responded promptly to sudden deterioration in clients' physical and mental health. Staff made clients aware of harm minimisation and the risks of continued substance misuse. Safety planning was an integral part of recovery plans.
- Staff understood how to protect clients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each client's physical health.
- Monthly meetings took place which focused only on discussion of clients with safeguarding risks. The safeguarding lead had undertaken audits which led to staff consistently undertaking a home visit for clients with young children to assess the safe storage of prescribed medicines.
- A mortality review was undertaken which confirmed there had been an increase in the number of client deaths by natural causes. It also identified an increasing number of older clients being treated by the service. This information was fed back to local authority commissioners and the local public health team, and the service was reviewing how it could enhance end of life care.
- 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.

However:

Summary of this inspection

- Although all clients' risk assessments documented potential risks, the full context of those risks was not always described.

Are services effective?

Good

We rated effective as good because:

- Staff completed comprehensive assessments with clients on accessing the service. They worked with clients to develop care plans and updated them as needed. The quality of care plans was varied, but all reflected clients' assessed needs.
- Staff provided a range of care and treatment interventions suitable for the client group and consistent with national guidance on best practice. They ensured that clients had good access to physical healthcare and supported clients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit.
- Managers had recognised that clients' access to Improving Access to Psychological Therapies was dependant on them being abstinent from substances for three months. They arranged for a worker from that service to attend the service two days per week. If a client was in treatment at the service, the three-month rule was waived.
- The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit clients. They supported each other to make sure clients had no gaps in their care. The team had effective working relationships with other relevant services outside the organisation.
- Staff supported clients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2015 and knew what to do if a client's capacity to make decisions about their care might be impaired.

However:

- A minority of clients' care plans were generic. Whilst they addressed clients' needs, they were not personalised or holistic.

Summary of this inspection

Are services caring?

Good

We rated caring as good because:

- Clients were involved in the service in a number of ways, including at the monthly service user forum. Client feedback had led to the development of a men's group, the service opening on Saturday's, a further weekly acupuncture session and extending the Thursday coffee mornings. Decisions about the service were made transparently and if new ideas could not be developed, there was an explanation and encouragement to identify an alternative.
- Clients could become service user representatives. They would lead on developments for an area of the service with a staff member. These areas included safeguarding and the capital card scheme.
- Staff treated clients with compassion and kindness. They understood the individual needs of clients and supported clients to understand and manage their care and treatment. Clients were very positive in their feedback concerning staff.
- Where appropriate, clients' families and carers, were involved in clients' care and treatment.

Are services responsive?

Good

We rated responsive as good because:

- The service was easy to access. Staff planned and managed discharge well. The service had alternative care pathways and referral systems for people whose needs it could not meet.
- Treatment rooms supported clients' treatment, privacy and dignity.
- The service met the needs of all clients, including those with a protected characteristic or with communication support needs.
- The service user forum identified activities in the community that clients would like to explore. These were then developed into 'taster sessions' and had included a horticulture visit and a picnic for world photography awards, including a photography competition for clients. The taster sessions were aimed at encouraging socialisation and community reintegration.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Are services well-led?

Good

We rated well-led as good because:

Summary of this inspection

- Leaders in the service had high levels of experience, capacity and capability to deliver high quality treatment and care. They provided compassionate, effective and inclusive leadership of the service and had developed a culture of openness, transparency and continuous improvement.
- The views of clients and families and carers were viewed as essential to the operation of, and developments in, the service. Groups for clients and families and carers were open and leaders in the service welcomed constructive challenge. Decisions regarding the service were made transparently with clients. If a new idea could not be developed, there was an explanation, and encouragement to identify an alternative.
- Individual staff members and service user representatives were the joint leads for specific areas of the service. They worked collaboratively to problem-solve and develop the service in those areas. This included areas not usually associated with client involvement, such as safeguarding.
- Staff described a respectful, supportive culture where they felt valued and motivated to provide high quality care and treatment. Staff were empowered to carry out their roles and there was a strong focus on career development. Staff were very positive concerning the leadership team and were proud to work for the provider.
- The service had an integrated governance system which provided effective and accurate monitoring and assurance of risks, issues and performance in the service. There were governance processes for all areas of practice. Leaders addressed areas for improvement with staff quickly and effectively.
- Leaders worked systematically, proactively and effectively with partners. The service led on identifying changes in the local population who misused substances and identifying areas of unmet need. This had included access to psychological therapies, the homeless population and the increasing number of older adult clients.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff had undertaken training in the Mental Capacity Act. The provider had a Mental Capacity Act policy which staff could refer to.

Staff were aware of when clients may lack capacity, for example when intoxicated. Staff knew the five principles and had a card with these on in their identification badge holder. Staff understood that clients could make unwise choices and retain capacity and that clients lacking capacity should be supported to make a decision wherever possible. Staff knew when they needed to seek further advice and assistance.

Substance misuse services

Good

Community-based substance misuse services

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

Are community-based substance misuse services safe?

Good

Safe and clean environment

The service was clean, well equipped, well-furnished and well maintained.

Safety of the facility layout

The service was on the first floor and had a stairlift from the ground floor. Rooms in the service were accessible for people with limited mobility, including a toilet. However, for clients with very limited mobility, staff saw them in the recovery hub which was at street level.

All rooms in the recovery hub had wall alarms to attract staff attention. Staff wore personal alarms when meeting with clients, which were tested weekly.

A fire risk assessment for the service and recovery hub was undertaken every six months. There was weekly testing of fire alarms and fire extinguishers had regular maintenance checks. A health and safety risk assessment had been undertaken for the service. Actions resulting from this risk assessment were monitored and addressed.

Maintenance, cleanliness and infection control

The service and recovery hub were clean and well maintained. Furniture was in good condition and areas for clients were comfortable.

Handwashing posters were above all sinks. Clinical waste was disposed of appropriately and there were sharps bins, for needles and sharp objects. These were checked regularly to prevent over-filling. Personal protective equipment, such as gloves, and a blood spillage kit were available. An infection control audit was also undertaken.

The service had a clinic room and two further assessment rooms where clinical equipment was used and stored. All of the rooms were clean and tidy. All medical disposable items were within their expiry dates and medical equipment was calibrated and clean. Emergency equipment consisted of a grab bag, oxygen and a defibrillator, to restart a person's heart, if necessary. All of the emergency equipment was in working order and checked regularly.

Safe staffing

There were a sufficient number of trained and skilled staff to meet the needs of clients. The service had improved since our last inspection when we told the provider there were not enough staff to meet clients' needs.

Staffing levels and mix

There were two registered nurses, one of whom was also a non-medical prescriber. Both of these posts were vacant but were filled by long-term agency staff. A staff grade psychiatrist, who was the clinical lead, worked in the service for two days per week.

There were a further 19 staff working in the service, including three team leaders, 13 practitioners and two administrators. There were two vacant practitioner posts. These were filled by agency staff whilst the service recruited to the posts. There were no other vacant posts in the service. In the previous year there had been eight staff leavers.

Staff leave was planned in advance to ensure there were sufficient staff to operate all parts of the service. Any unplanned absence was discussed in the morning staff meeting. There was a proactive plan for unplanned absence. Both the duty manager and duty practitioner for each day had empty appointment slots to see clients in the event of unplanned staff absence.

Practitioners had caseloads of 50 to 60 clients. Practitioners caseloads were mixed in terms of complexity and the type of treatment clients were receiving. This ensured that practitioners were able to spend enough time with all clients.

Sickness absence was 5% in the year before this inspection.

Mandatory training

Staff completion of mandatory training was 93%. One staff member was booked to undertake safeguarding adult training. After this all staff would have completed all mandatory training. This was an improvement since our last inspection when we told the provider to ensure staff completed all mandatory training. Mandatory training for staff included various health and safety training, infection control, professional boundaries and motivational interviewing.

Assessing and managing risk to patients and staff

Staff undertook an assessment of clients' potential risks when they first attended the service. Staff then developed risk management plans with clients to minimise such risks. These included the risk that clients may disengage with treatment at the service. This was an improvement from the previous inspection when we told the provider to ensure clients had appropriate risk assessments and management plans, including unplanned exits from treatment. Comprehensive audits of clients' care and treatment records were undertaken and the manager had well developed plans to further improve the quality of clients' risk assessment and management plans.

Assessment of patient/service user risk

We reviewed nine clients' care and treatment records. Clients' potential risks were clearly recorded, including risks concerning their substance misuse, self-neglect and risks of self harm or suicide. Other areas, such as childcare, physical health, sexual health, housing and violence were also included in clients' risk assessments. Two clients' risk assessments were basic but did document the clients' potential risks. Other clients' risk assessments were detailed and comprehensive.

Staff understood clients' potential risks and took action when the level of risks changed, which they recorded. When clients' risks increased staff discussed this in the morning staff meeting. Examples included a client whose appearance indicated self-neglect and another client who began using alcohol during alcohol detoxification treatment.

Management of patient/service user risk

Staff managed clients' potential risks well with clear plans on how to reduce these risks. Staff regularly provided clients with harm minimisation advice concerning their substance misuse. This included providing opiate users with naloxone, a medicine that can block the effects of opiates, and advice on its use, and warning of the dangers of alcohol consumption with opiate treatment. The service also offered a needle exchange programme, available to clients and people who were not using the service. Clients also had risk management plans concerning the risk of early exit from treatment. These plans included the risks of restarting drug use, such as overdose. The risks of alcohol withdrawal seizures if clients left alcohol detoxification treatment early, were recorded and discussed with clients. When staff met with clients, they focused on potential risks to clients or others and identified when risk levels had changed.

Clients prescribed high doses of methadone, or otherwise at risk of heart abnormalities, had an electrocardiogram when they started treatment. This followed best practice guidance (Drug misuse and dependence: UK guidelines on clinical management, Department of Health, 2017) and ensured that any risks caused by heart abnormalities were minimised.

Clients' care and treatment records were stored electronically and the providers' system allowed specific risks to be highlighted on clients' records. For example, if a client displayed aggressive behaviour frequently, or with a particular member of staff, this would be highlighted on the clients' care record.

Staff visited clients at home when this was considered necessary. Staff only conducted home visits in pairs following a risk assessment. There was a well-established

system for minimising risks for home visits, including staff having mobile phone access and contacting the service following visits. A recent audit had identified that staff had advised clients on the safe storage of medicines when clients lived with children. However, they had not consistently checked if clients safely stored medicines. For medicines, such as methadone, there is a significant risk of overdose if taken by a child. Action had been taken as a result of the audit. Staff now visited clients at home within 10 days of a prescription to check safe storage. The service had specific storage containers they gave to clients who lived with children.

Safeguarding

Staff understood how to protect clients and others from abuse and harm.

All team leaders and managers had undertaken level 5 safeguarding adults and safeguarding children training. All other staff had undertaken level 3 safeguarding adults and safeguarding children training.

Staff were able to identify different types of abuse and described how they could protect clients and others from abuse or neglect. This included children who had contact with clients and clients who were vulnerable to exploitation. Staff provided examples of making a safeguarding referral due to risks to children, domestic violence and gender-based violence.

One of the team leaders was the safeguarding lead for the service. They undertook a monthly review of all clients on the safeguarding tracker system. All staff met monthly to discuss clients where safeguarding risks had been raised. In addition, the safeguarding lead had undertaken audits to ensure staff were able to effectively identify and act on information which could lead to a safeguarding referral. This included identifying clients who had children or access to children and the safe storage of clients' medicines. These audits had highlighted areas for improved practice and a number of changes had been made. This included additional 'tags' on clients' electronic care records indicating if clients had access to children or there were other safeguarding concerns. Staff provided positive feedback regarding these additional prompts. The changes were being audited quarterly to monitor their effectiveness.

Staff attended meetings when safeguarding of clients or others were discussed. These included professionals' meetings, multi-agency risk assessment conferences and safeguarding strategy meetings. Staff in the service worked effectively with other agencies to safeguard children and adults.

Staff access to essential information

Staff used an electronic care record system to records details of clients' care and treatment. All staff had access to this system. The electronic system had several alerts which could be placed on clients' records to assist with monitoring risks.

Medicines management

The management of medicines in the service was safe. At our last inspection, we told the provider to ensure staff followed the policy for the storage and procedures for prescriptions. This had improved at this inspection.

Controlled drugs were not held on the premises. Clients were dispensed prescribed medicines at a number of local pharmacies. Staff from the service provided bi-monthly training to all pharmacies including sharing best practice.

Medicines were stored appropriately, including Hepatitis B vaccinations which were refrigerated. Nursing staff undertook daily checks, including the refrigerator and room temperatures. Naloxone injections were available for staff to give to clients who used opiates. Staff provided guidance to clients on how and when to use naloxone and staff had completed competency checks to be able to provide this advice. Adrenaline was also stored in the service as part of an anaphylaxis kit. All medicines were within their expiry date.

Prescriptions for clients' medicines were recorded correctly, including a log of prescription numbers. There was a monthly audit of prescriptions, including those which were void. All staff had received FP10 (a prescription form) training and reported any prescription errors. Staff in the service contacted community pharmacies to confirm if clients had presented with their prescriptions. For a very busy pharmacy, staff faxed the information concerning clients. This resulted in a quicker response than contacting the pharmacy by phone.

Track record on safety

There had been 24 serious incidents in the service in the previous 12 months. The provider's threshold for a serious incident was different from NHS services. Ten serious

Good

Community-based substance misuse services

incidents involved the death of clients, nine of which were from natural causes. Ten serious incidents involved potential or actual abuse or neglect; six of clients and four of children. There were two serious incidents involving clients being aggressive and two concerning clients who had taken an overdose or had suicidal ideas.

The management team suspected that there had been an increasing number of clients who died than previously. A mortality review was undertaken to identify if this was the case and if there were themes or trends. This concluded there had been an increase in client deaths from natural causes. It also concluded that the service was increasingly treating older clients. This information was provided to local authority commissioners and the local public health team, and the service was reviewing how it could enhance end of life care.

Reporting incidents and learning from when things go wrong

Staff in the service knew what incidents to report and reported a range of incidents. These included prescription errors and client aggression and accidents. Incidents were reviewed at the monthly integrated governance meeting and shared in 'key messages' with staff. For example, following a patient death, suicide awareness training was taking place the month following the inspection. This training would have an emphasis on professional curiosity. Staff in the service also provided learning from incidents with community pharmacies.

Staff understood the duty of candour. Duty of candour is a legal requirement. It means providers must be open and transparent with clients about their care and treatment when something goes wrong.

Are community-based substance misuse services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Clients had a comprehensive assessment when they first attended the service and had a care plan developed based on their assessed needs.

We reviewed nine clients' care and treatment records. Staff assessed clients when they first attended the service. This assessment was comprehensive and included clients' physical and mental health, substance misuse and social circumstances. Clients' having alcohol detoxification treatment were also assessed by a registered nurse or a doctor. These assessments included blood tests and use of The Alcohol Use Disorders Identification Test and the Severity of Dependence Questionnaire. Using these assessment tools followed best practice guidance (Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence, National Institute for Health and Care Excellence [NICE], 2011). Clients using heroin, or other opiates, were assessed by the registered nurse prescriber, using the Clinical Opiate Withdrawal Scale (COWS), as recommended by best practice guidance (Drug misuse and dependence: UK guidelines on clinical management, Department of Health [DH], 2017).

Clients' care plans varied in their quality. Three clients' care plans were generic and not person-centred, although they did meet clients' needs. The remaining six clients' care plans were detailed and comprehensive. They demonstrated that clients had been involved in developing their care plans. The service manager had identified that there was inconsistency in the quality of clients' care plans through comprehensive audits. A workshop on care plans and risk assessments was planned for the next integrated governance meeting.

Best practice in treatment and care

Clients' care and treatment followed best practice guidance.

We reviewed nine clients' care and treatment records. Clients with heroin or opiate dependence were prescribed buprenorphine or methadone, with a gradual dose increase at the start of their treatment, as recommended by best practice guidance (DH, 2017). Clients provided urine drug screen tests during their treatment and had a medical review of their treatment every three months. Best practice guidance was followed.

For clients with alcohol misuse problems, the severity of their dependence was based on their SADQ score. This then indicated if they had community detoxification treatment or were required to attend the pre-detoxification alcohol group for six weeks before community alcohol

detoxification. There were clear exclusion criteria for community alcohol detoxification, such as clients having a past history of seizures. When clients had alcohol detoxification, information was provided to them and an adult who would remain with the client. Clients having alcohol detoxification attended the service every day for the first five days. Staff gave clients a breathalyser test and checked their blood pressure and pulse. Staff used the Clinical Institute Withdrawal Assessment for Alcohol Scale, Revised to monitor clients' withdrawal signs and symptoms. This followed best practice guidance (NICE, 2011). Following clients' assessment, staff wrote to clients' GPs requesting that they prescribed the medicine thiamine, if they had not already done so. Thiamine is prescribed to minimise memory loss caused by alcohol misuse. The service did not store, prescribe or administer high potency injectable vitamin B for clients at high risk of memory loss. However, there were well developed plans to begin doing so. Following alcohol detoxification, clients attended the post-detoxification group for four weeks and were offered medicine to minimise their risk of relapse. This followed best practice guidance (NICE, 2011).

When clients were assessed for treatment they were offered blood borne virus testing. Clients could also have Hepatitis B vaccinations in the service. There was a strong focus on health promotion and harm minimisation throughout the service. The needle exchange would open at any time during the day when someone wanted to use it, including people not in treatment with the service. Staff also provided harm minimisation advice. The corridors of the service had an abundance of information aimed at clients' motivation and health promotion. This included information on chemsex and sexual health. In the recovery hub, it was 'heart health' month with a range of displays providing advice in how to improve cardiac functioning through diet and exercise. There was also a sugar awareness event encouraging clients to think about how they consume sugar. The health promotion displays and events changed regularly at both sites. Information was also available to clients concerning abortion and contraception.

Clients attended a range of psychosocial groups in the service. These included brief interventions, alcohol reduction groups and relapse prevention groups. Based on cognitive behaviour and motivational interviewing approaches, these groups should be delivered alongside prescribed medicines (NICE, 2011; DH, 2017). For clients using stimulants, there was a brief cocaine interventions group and auricular acupuncture.

Clients' individual meetings with staff were based on motivational interviewing, an evidence-based model to support behaviour change. Some staff had additional training and experience and could deliver brief cognitive behaviour interventions.

Monitoring and comparing treatment outcomes

The service compared and monitored treatment outcomes to measure the effectiveness of treatment.

The service submitted data to the National Drug Treatment Monitoring System (NDTMS). This meant the provider could compare the service to similar services nationally, regarding outcomes for clients.

The outcomes concerned clients completing treatment in a rolling 12-month period. For non-opiate clients, outcomes were in the top 25% of services (44.7% completion). For opiate clients, the service was approaching the top 25% of services (7.4% completion) following gradual improvement in the previous six months. For clients having alcohol treatment, the service was approaching the top 25% of services (42.2% completion).

Skilled staff to deliver care

Staff had the right skills, knowledge and experience to deliver care and treatment to clients in the service. The service had improved since our previous inspection when we told the provider to ensure staff received regular supervision.

Staff in the service included a doctor and registered nurses, one of whom was a non-medical prescriber. Team leaders provided management support to practitioners.

Staff undertook a comprehensive induction when they first started working in the service. This included regular meetings with their team leader, a review of policies and identification of the staff members' strengths. Staff were trained in the Mental Capacity Act, equality and diversity and motivational interviewing as part of their induction.

Staff had training in a number of areas specific to service needs. Practitioners had completed training in motivational interviewing and dry blood spot testing for

Good

Community-based substance misuse services

blood borne viruses. There were plans for practitioners to be trained to conduct electrocardiograms. All practitioners and nursing staff had competency assessments concerning the advice they gave to clients when dispensing naloxone.

The provider had a recruitment policy which staff followed. This included conducting Disclosure and Barring Service checks and receiving professional references for staff. Volunteers also had a Disclosure and Barring Service check.

All staff had supervision every month. Staff supervision included discussion of clients' safeguarding referrals and a review of clients' care records. Staff members' training needs were also reviewed during supervision.

All staff who worked in the service for more than six months had an appraisal. The appraisal summarised their previous supervisions and identified staff members' strengths and career development goals. An external psychologist also facilitated group reflective practice for staff.

There was a policy and clear processes for managers to deal with poor staff performance, and the manager and team leaders had undertaken training to manage this.

The service had 14 volunteers, of whom three were peer mentors. All of the volunteers were supported and had supervision with a team leader. The peer mentors undertook the provider's training course, a qualification, and a peer mentoring placement, before becoming peer mentors. They received ongoing support and supervision from the management team.

Multi-disciplinary and inter-agency team work

Multi-disciplinary working was embedded in the service and staff worked with many different agencies and professionals to provide effective care and treatment. At our previous inspection we told the provider they must ensure regular communication and information sharing with GPs. At this inspection that was no longer an issue.

Clients in the service had multi-disciplinary assessments with input from the doctor or nursing staff. Clients were regularly discussed in morning meetings and weekly multi-disciplinary meetings. All clients had a designated keyworker in the service.

Staff worked with a range of other agencies including probation, mental health services and client's GPs. Staff contacted community mental health teams to involve them in clients' recovery plans. Managers had recognised that clients' access to Improving Access to Psychological Therapies was dependant on them being abstinent from substances for three months. They arranged for a worker from that service to attend the service two days per week. If a client was in treatment at the service the three-month rule was waived.

Staff in the service had also recently delivered drug and alcohol training sessions to the local community mental health and to the local authority housing teams.

Good practice in applying the Mental Capacity Act

All staff had undertaken training in the Mental Capacity Act. The provider had a Mental Capacity Act policy which staff could refer to.

Staff were aware of when clients may lack capacity, for example when intoxicated. Staff knew the five principles and had a card with these on in their identification badge holder. Staff understood that clients could make unwise choices and retain capacity, and that clients lacking capacity should be supported to make a decision wherever possible. Staff knew when they needed to seek further advice and assistance.

Are community-based substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Clients in the service valued their relationships with staff. Staff provided emotional and practical support, supported clients to access other services and respected clients' individual circumstances and views.

We observed staff speaking with clients with kindness and respect. Staff displayed empathy and compassion with clients, respected clients' privacy, and maintained clients' dignity.

All of the clients spoke very highly of staff in the service. They described being fully involved in their care and treatment and of developing strong therapeutic relationships with staff. They found staff supportive and able to provide practical and emotional assistance. In the 2019-2020 survey, 73% of clients were very satisfied with

the service and 17% were somewhat satisfied. In the same survey, 81% of clients responded that the service was safe and 79% responded it was caring. Sixty per cent of clients rated the service as excellent.

All of the staff we spoke with had no concerns with being able to raise concerns about the victimisation, discrimination or harassment of clients. Staff were able to provide examples of when they did so, and these often involved a safeguarding referral.

Staff supported clients to access other services. For example, staff assisted clients with accessing the LEA project, a charity helping people who wish to leave sex working. Staff also supported clients to access domestic violence organisations and assisted with appointments for clients to attend the local authority parenting advice service.

The provider had a policy concerning confidentiality which reflected current legislation and guidance. Staff understood the importance of maintaining client confidentiality. They provided examples of when they had to protect confidentiality in situations where more than one client of the service was involved. Clients in the service were made aware of confidentiality when they first attended the service. Clients indicated who they consented information about them was shared with.

Involvement in care

Involvement of patients/service users

Staff worked with clients to involve them in their care and treatment. The service operated transparently, and clients were involved in decisions concerning the service.

Staff adopted a person-centred approach to clients and spent time with clients to gain a thorough understanding of their needs. Staff used pictorial or visual aids and interpreters when clients had communication difficulties. Clients were offered copies of their care plans. However, staff did not always record when they had done so.

Staff supported and empowered clients to access advocacy services. Staff directed clients to five local advocacy services to assist clients with a range of issues.

Clients were involved in the operation of the service in a number of ways. Clients could use the feedback box in the reception area. This feedback was then reviewed at the monthly service user forum. At this forum, clients met with staff to make suggestions for developing the service further. Some groups, such as the men's group and cocaine interventions group had been developed following client feedback. Client feedback also led to the service opening on Saturdays, extending the Thursday coffee morning, a further weekly acupuncture session and more activities on the timetable. A 'you said, we did' board highlighted how client feedback could effect changes in the service.

The service was undertaking a survey of clients and staff concerning the group programme and possible changes. This was part of the quarterly consultations with clients regarding different aspects of the service.

Decisions about the service were made transparently with clients. If a new idea could not be developed, there was an explanation, and encouragement to identify an alternative. In the 2019 to 2020 survey, clients were asked how well staff had listened and responded to feedback. Of 53 clients responding, 37% of clients felt the service was extremely responsive, 37% felt it was very responsive, and 15% felt it was somewhat responsive.

Clients could also become service user representatives. They would lead on developments for an area of the service with a staff member. These areas included safeguarding and the capital card scheme.

Involvement of families and carers

With clients' consent, family members and carers were involved in clients' treatment in the service. They were able to provide feedback about the service and discuss their own needs. On some occasions, clients' family members or carers met separately with staff to discuss how they could support a client. For some family members and carers, the service offered weekly counselling. The service also held a weekly relative's group. This group was facilitated by staff and provided peer support for clients' family members or carers.

The service had well-developed plans to undertake a targeted consultation with family members and carers. This was being developed alongside a specific family and carer's survey. These were to identify any further support the service could offer family members and carers.

Are community-based substance misuse services responsive to people's needs?

Good

Community-based substance misuse services

(for example, to feedback?)

Good

Access, waiting times and discharge

There was a system for ensuring new clients were assessed shortly after referral or self presenting to the service. Urgent appointments were offered for clients at increased risk. Staff liaised with other services when clients were being discharged using clear pathways.

When referrals were received, or clients self-presented, they were invited to first attend an induction group. There were two induction groups operated every week and clients did not wait longer than two days to be booked into a group. The induction group was designed to inform clients about the service, including the group programme. It was also an opportunity to reinforce new clients' motivation to address their substance misuse problems.

Clients were booked in for an assessment appointment at the end of the induction group. The service aimed for clients to be assessed within five days of the induction session. In some cases it was longer before clients were assessed, due to them not being available to attend the assessment. All clients were assessed by the service within two weeks of the induction group.

The service received referrals from many services including prisons, probation, GPs, the local authority, mental health services and job centres. Clients could also self-refer. The hospital liaison worker for the service worked in the local general hospital and also assessed clients for possible treatment at the service.

The service identified clients with increased potential risks. These included clients who injected drugs, were pregnant, had just been released from prison or were homeless. Assessment slots were available each day for the urgent assessment of these clients. Assessment slots were also available on some evenings. When it was considered necessary, due to risks, new clients attended an assessment without having to first attend the induction group.

The service was not commissioned to undertake outreach work with homeless people. However, managers recognised this was a significant local issue. They were working with the local authority homeless person's lead to develop ways to make the service more accessible for homeless people.

The service did not have any exclusion criteria for adults with substance misuse problems.

Discharge and transfers of care

In the 12 months before the inspection, the service discharged 423 clients from care and treatment. There was a weekly discharge meeting to ensure accurate recording of all clients who were discharged.

Staff in the service ensured that other agencies and services were informed when clients were being discharged from treatment. There was good liaison, and clear pathways, for clients to be referred to other services.

The facilities promote recovery, comfort, dignity and confidentiality

The service had enough rooms for clients to meet staff in private. Rooms were adequately soundproofed to maintain clients' confidentiality.

The recovery hub had a communal kitchen and a small garden area. In the garden, there were pot plants and clients had painted a mural on a wall. Clients had also previously grown vegetables in the garden. All areas of the recovery hub were shared spaces and there were no staff offices or areas only for staff, except behind the reception area.

Patients'/service users' engagement with the wider community

Staff encouraged clients to maintain contact with their families and carers and seek support from them where possible.

The provider had developed the 'capital card' scheme, where clients could collect reward points for engaging in various aspects of treatment. Clients could then use these points in a number of ways, such as purchasing cinema tickets, driving lessons or retail items. This is known as contingency management and follows best practice guidance (Drug misuse and dependence: UK guidelines on clinical management, Department of Health [DH], 2017). The capital card scheme had won awards and clients could spend points in the recovery hub on second hand clothes or books.

Good

Community-based substance misuse services

Clients in the recovery hub were supported to gain employment. A jobs club was held to provide clients with advice and support on applications, and a computer was available for clients to use to search and apply for jobs or further education. Staff in the recovery hub also held a workshop for clients to develop interview skills.

Following client feedback the service had recruited a building recovery in communities co-ordinator. They offered a wider range of skills-based groups, particularly for clients leaving residential rehabilitation. At the time of the inspection, the co-ordinator was consulting with clients and group facilitators to develop more groups based on clients' needs and preferences.

The service user forum identified activities in the community clients would like to explore. The service then developed 'taster sessions' for clients to encourage socialisation and reintegration into the community. This had included a horticulture visit and a picnic for the world photography awards, including a photography competition for clients.

Meeting the needs of all people who use the service

Staff had a good understanding of the varied needs of clients. The local population was not as diverse as most other areas of London. Nevertheless, staff were able to identify and understand the particular needs of different groups of people, including those with protected characteristics.

A sign at the entrance to the service stated it was LGBT inclusive. The group timetable was available in an easy-read version, and pictorial and visual aids were available to be used with clients with limited reading ability. Leaflets could be obtained from the provider's head office in a range of languages and where required, interpreters would be used for clients.

The mortality review and hospital liaison practitioner had identified an older group of clients with substance misuse problems. Working with the service commissioner and local public health team, the registered manager was reviewing the specific care required for this group of clients. This included working with other organisations, in some cases, to provide aspects of end of life care.

A stairlift provided access from street level to the service. Following client feedback, the service purchased a wheelchair to assist clients' mobility in the service. In some cases, clients were seen by staff in the recovery hub which was fully accessible.

Referral and assessment forms for clients contained questions concerning protected characteristics and interpretation. This meant that staff in the service were aware of, and could prepare, to meet new clients' particular needs.

Listening to and learning from concerns and complaints

There was a well-established complaints procedure which was advertised in the service. Clients, or family members of carers, who made a complaint were treated fairly and did not experience any negative consequences from making a complaint.

There were complaints posters and leaflets available in the reception of the service. In the 2019 to 2020 client survey, 78% of clients said they knew how to make a complaint. Complaints were viewed as a way to learn and improve the service. Whenever clients expressed dissatisfaction with the service they were asked if they would like to make a complaint. Staff, volunteers or peer mentors assisted clients with putting complaints into writing. When a client, family member or carer made a complaint there was an expectation that this should not affect how they were treated at the service. Clients who made a complaint had face-to-face meetings with the investigating manager concerning their complaint and any issues surrounding it.

There had been eight complaints in the service in the previous year. Four of these complaints had been upheld. Complaints were responded to within 28 days wherever possible. When the investigation was completed, the investigating manager met face-to-face with the complainant again to explain the outcome. This was also an opportunity to receive more feedback about the complainant's views.

The provider had a well-established system to review complaints. All complaints were reviewed quarterly by the provider's board to identify themes and trends to share with services. At a service level, complaints were reviewed

Good

Community-based substance misuse services

in the local integrated governance meeting. Learning from complaints was shared by communicating 'key messages' to staff. When appropriate, feedback from complaints was given to individual staff members during supervision.

Are community-based substance misuse services well-led?

Good

Leadership

Leaders in the service had high levels of experience, capacity and capability to deliver high quality treatment and care. They provided compassionate, effective and inclusive leadership of the service. Leaders promoted a strong ethos of client involvement and spent time with staff to understand the demands placed on them and to seek ideas to improve the service. Leaders sought new ways to maximise client access and retention in the service, such as engaging with the local authority homeless lead, identifying the increasing number of older adult clients, and ensuring clients could access psychological support from another provider. Leaders effectively identified the priorities and challenges in the service. They understood the service well, worked to improve the service, and maintained high standards.

There was strong clinical leadership in the service. The service doctor, non-medical prescriber and registered nurse were all very experienced and were fully aware of, and followed, best practice guidance.

Leaders in the service were approachable and visible to staff, clients and families and carers.

Staff in the service had a clear understanding of what recovery was for clients. These mirrored the provider's view of recovery; that clients could reintegrate and become purposeful members of society.

Vision and strategy

The provider had four values; entrepreneurial, working in partnership, strong belief in service users and being community focused. Staff understood the vision and values of the provider and demonstrated this in the way they worked with clients, their families and carers.

Leaders had a strategy for the service, which included communication, development and joint working with partner agencies to provide whole system care. At the time of the inspection, the service was being recommissioned. Leaders met with staff to discuss this and support them. In a recent audit, staff reported having a clear vision and direction for the service and their role within it.

Culture

Leaders in the service inspired and motivated staff in their work, and there were high levels of staff satisfaction. Staff described a respectful, supportive culture, where they felt valued and motivated to provide high quality care and treatment. Staff were empowered to carry out their role and there was a strong focus on career development. Staff described high levels of morale and low levels of stress. All of the staff we spoke with were very positive concerning the leadership team and were proud to work for the provider.

Managers had recently introduced a team member of the month award. The decision on who this was each month was based on formal and informal staff feedback. Staff saw this as reflective of the leadership style in the service.

There were a number of opportunities for staff to develop their careers. In addition to staff members individual learning needs, staff could attend brief therapy training. Team leaders attended aspiring managers training. A new member of staff was starting to shadow clinicians and other staff so they could progress to become a practitioner. There was a clear focus on ensuring equality and diversity in recruitment and training decisions. Managers in the service spent time with staff considering career development opportunities.

Staff were actively encouraged to speak up about concerns and there were provider policies to support this. All of the staff we spoke with felt trusted and supported to raise concerns with leaders in the service. They had no anxieties in doing so.

Teams and individual practitioners in the service worked well together.

Governance

There was a well developed and well-established governance system in the service. At our previous

inspection we told the provider to improve the governance system concerning learning from incidents, training, supervision and risk management. At this inspection, the service had improved in these areas.

Governance procedures, policies and process were reviewed and updated as required. These systems were changed to be responsive to local needs and updated guidance. The leadership team developed new processes and guidance to provide quality assurance of developments in the service. These included a targeted consultation with families and carers, training staff to undertake hepatitis blood spot testing, and an enhanced safeguarding audit focusing on safe practice.

Leaders in the service had a systematic approach to working with other organisations to improve care and outcomes for clients. They had collected data to demonstrate the client need for Improved Access to Psychological Therapies and the barriers to clients accessing this. This had resulted in a worker attending the service twice per week and exemption of the time period for abstinence for clients to receive treatment. Having undertaken a structured mortality review, leaders presented their findings to local authority commissioners and the local public health team to work with them on improving care and treatment for older adults.

All aspects of service delivery were subject to audit and there was clear evidence of learning from incidents and complaints. Standard agenda items for team and governance meetings included important aspects of service delivery, such as incidents and safeguarding referrals.

The system of training, monitoring and audit for safeguarding referrals enhanced the safety of clients and others and best practice guidance concerning substance misuse treatment was consistently followed.

Notifications were made to external bodies, such as the Care Quality Commission, when required.

The provider had a whistleblowing policy in place.

Management of risk, issues and performance

The service had an integrated governance system which provided effective and accurate monitoring and assurance of risks, issues and performance in the service. There were governance processes for all areas of practice in the service. There was a robust system for data collection. This included a weekly discharge meeting which ensured discharge and outcomes data was effectively recorded for the service. Leaders could be assured that performance information was accurate.

In addition to monthly safeguarding meetings, there were weekly multidisciplinary meetings, two- weekly leaders' meetings and an integrated governance meeting. In all of these meetings there was a clear focus on risks or other issues or difficulties concerning the service.

Audits provided assurance that best practice was being followed and identified areas for improvement. This had included safeguarding practice and the quality of care plans and risk assessments. Leaders addressed areas for improvement with staff quickly and effectively. Safeguarding practice had improved and workshops for care planning and risk assessment were planned to take place shortly after the inspection.

Staff supervision and appraisals included reviews of staff members' work and identified areas for improvement.

The service had a contingency plan for emergencies. Should the service have to close its current premises there were well developed plans to relocate to a neighbouring service operated by the provider. Clients' care and treatment records were stored on the provider's IT system and could be remotely accessed from other locations.

Managers in the service actively monitored staff sickness and absence. The provider had policies concerning sickness and absence and all leaders had undertaken training in these areas.

Information management

Information management systems were not burdensome to staff and provided up to date, accurate, information concerning the service and individual clients. Client confidentiality was assured and reviewed regularly.

Staff had access to the equipment and technology necessary for their roles and managers could easily access up to date service information to monitor performance. Service and client information was shared within the staff team and used effectively to make decisions and drive developments. The service also shared information effectively with partners, such as the data concerning Improved Access to Psychological Therapies and mortality review information.

Good

Community-based substance misuse services

All clients' information was accessible to staff and there were systems in place to ensure the confidentiality of client information. Confidentiality was regularly reviewed with clients concerning consent to provide information to other agencies or individuals.

Engagement

Leaders in the service consistently demonstrated high levels of constructive engagement with staff, clients and their families and carers. This included groups with protected characteristics.

Staff were fully informed about changes and developments in the service through regular meetings. A client newsletter and the providers' website provided information for clients and their families and carers.

The views of clients and families and carers were viewed as essential to the operation of, and developments in, the service. Groups for clients and families and carers were open and leaders in the service welcomed constructive challenge. Decisions regarding the service were made transparently with clients. If a new idea could not be developed, there was an explanation, and encouragement to identify an alternative. Where possible leaders adopted clients and families and carers views to improve the service. This had included addressing psychological support for clients, opening the service on Saturdays and changing or providing specific additional groups. A 'you said, we did' board recorded how the service had responded to clients' feedback.

In addition to surveys of clients, they could also provide feedback in the service user forum, via service user representatives, volunteers, peer mentors or staff. There was also a feedback box in reception. Individual staff members and service user representatives were the joint leads for specific areas of the service. They worked collaboratively to problem-solve and develop the service in those areas. This included areas not usually associated with client involvement, such as safeguarding.

The provider's senior team visited the service regularly and were accessible to clients and their families and carers. Regular quality and pharmacy visits were undertaken.

Leaders in the service proactively engaged with other agencies, services and stakeholders.

The service took a leadership role locally in monitoring changes in the local population who used substances. Changes in the population profile led managers to engage with the local public health team and local authority commissioners. They had also engaged with the local authority regarding people who were homeless and the Improving Access to Psychological Therapies service to overcome barriers to clients receiving psychological treatment.

Learning, continuous improvement and innovation

The service had a fully embedded and systematic approach to driving continuous improvement in the service. The governance system, engagement and culture in the service supported these improvements. Leaders in the service were proactive in seeking out ways to improve the quality and safety of the service.

There were plans to have an onsite hepatology clinic and to improve homeless people's access to the service. Leaders were also in the process of developing a joint protocol with the local mental health NHS Trust.

The service had recently introduced a team member of the month award. Staff were positive about this development. The decision on who was the team member of the month was made by managers based on formal and informal feedback from staff. Recently a new receptionist had been given the award.

Outstanding practice and areas for improvement

Outstanding practice

- Monthly staff meetings focused on discussing clients with safeguarding risks. The safeguarding lead had undertaken a revised audit, resulting in staff consistently undertaking a home visit for clients with young children to assess the safe storage of prescribed medicines. The process for monitoring and auditing safeguarding referrals and actions enhanced the safety of clients and others.
- The outcome of a mortality review was fed back to the local authority commissioners and the local public health team, concerning the increase in older adults using the service. Leaders were working with partners to identify ways to enhance clients' care, including end of life care.
- Leaders had recognised that clients' access to Improving Access to Psychological Therapies was dependant on them being abstinent from substances for three months. They had arranged for a worker from that service to attend the service two days per week. If a client was in treatment at the service the three-month rule was waived.
- The views of clients and families and carers were viewed as essential to the operation of, and developments in, the service. Groups for clients and families and carers were open and leaders in the service welcomed constructive challenge. Decisions regarding the service were made transparently with clients. If a new idea could not be developed, there was an explanation, and encouragement to identify an alternative.
- Individual staff members and service user representatives were the joint leads for specific areas of the service. They worked collaboratively to problem-solve and develop the service in those areas. This included areas not usually associated with client involvement, such as safeguarding.
- Leaders in the service had high levels of experience, capacity and capability to deliver high quality treatment and care. They provided compassionate, effective and inclusive leadership of the service and had developed a culture of openness, transparency and continuous improvement.

Areas for improvement

Action the provider SHOULD take to improve
Action the provider SHOULD take to improve

The provider should ensure that all clients' risk assessments have detailed information so that staff fully understand the context of potential risks.

The provider should ensure that clients' care plans are detailed, holistic and demonstrate that clients have been involved in their development.