Westminster Drug Project 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

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

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

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

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

Overall summary

We do not currently rate independent standalone substance misuse services.

We found the following areas where the service provider needs to improve:

- Staff did not always follow the service policy to store, generate and issue prescriptions for controlled drugs and other medicines. Medicines were not stored at a safe temperature or in area where staff could monitor the temperature.
- Staffing levels did not meet the needs of the clients. There were staff vacancies and although agency staff were used, this still left shifts which were uncovered. Staff had caseloads of between 50 and 60 clients and some staff we spoke with did not feel that that staffing levels were safe since commissioners had approved the redesign of the service. Clients said they were not always told when their key worker changed.

Summary of findings

- Risks and management of risk were not clearly recorded. Staff had not developed management plans for unplanned exits of clients from the service.
- Mandatory training was not up to date and some staff did not receive regular supervision.
- The service did not consistently communicate with GPs.
- The service did not have robust governance processes to ensure the service operated effectively. We did not see evidence of learning from incidents and whilst some staff could describe examples of learning from incidents, others were unable.

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

- The service provided treatment for alcohol withdrawal through an ambulatory detoxification programme. Ambulatory detoxification. The service had a policy and procedure that described a client's suitability for the programme in line with National Institute for Health and Care Excellence National (NICE) guidance .The service had a policy in place for establishing safe starting doses for substitute medicines for clients known as titration.
- The building was clean and well maintained. The service had a reception area that was spacious and bright. The service had recently lowered the desk to create a more inviting atmosphere.
- Staff worked together and supported each other well to provide support, care and treatment to clients.
- Staff had a good understanding of safeguarding adults and children and how to make an alert.
- We observed that staff demonstrated a welcoming attitude to clients. Clients spoke positively about staff and described them as helpful. Clients could provide feedback about the service and were invited to attend fortnightly service user meetings to discuss issues within the service. Clients knew how to make a complaint about the service. There were no restrictions on anyone accessing the service.
- The service recorded client outcomes using the Treatment Outcome Profile (TOPs). The service measured outcomes when clients entered treatment and every three months.

Summary of findings

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Background to Westminster Drug Project Havering

Westminster Drug Project Havering is registered to provide the following regulated activity:

- Treatment of disease, disorder or injury

Westminster Drug Project Havering provides a drug and alcohol treatment service for adults in the London borough of Havering. The service provides advice and information, detoxification, substitute prescribing and psychosocial services. The service had been operating for just over 12 months. Prior to this a different provider operated the service.

The service had 478 clients on their caseload at the time of the inspection. Clients were seen on a regular basis at a frequency depending on the stage of their recovery or treatment.

There was a registered manager for the service.

The Care Quality Commission had not previously inspected this service.

Our inspection team

The team that inspected the service comprised of two CQC inspectors, a CQC inspection manager, a CQC pharmacist inspector, a specialist advisor who was a consultant psychiatrist in addictions and a specialist advisor who was a nurse in addictions.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited the service, looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with one client
- spoke with the service manager, operations manager and chief pharmacist
- spoke with seven other staff members employed by the service provider, including nurses and recovery workers

Summary of this inspection

- spoke with three peer support volunteers
- attended and observed a team meeting
- observed an individual consultation with a client and recovery worker
- looked at nine care and treatment records, including medicines records, for clients
- looked at 21 staff recruitment and training records
- looked at policies, procedures and other documents relating to the running of the service.

Following the inspection we spoke with a further eight clients by telephone regarding their experience of the service.

What people who use the service say

Clients were positive about staff and described them as helpful, caring and non-judgemental. Clients felt that staff were cheerful and welcoming and they would always be able to speak to someone. However they did note that this was not always their keyworker. Some clients we spoke with felt that there were not enough people on the reception desk at times and this led to them waiting outside for extended periods. Clients mostly liked the environment. However, a few told us they did not like the atmosphere during the recent renovation work to improve the environment.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

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

- Staff did not always follow the service policy to store, generate and issue prescriptions for controlled drugs and other medicines.
- We had concerns over staffing at the service. Staff had high caseloads; the service had a turnover rate of 47% and a high number of shifts remained unfilled.
- The service had not developed client risk management plans for unplanned exits. Potential risks and how these should be addressed were not always clearly recorded. There were no plans to review or manage risks.
- Staff mandatory training was not up to date. The service did not have an efficient process to monitor staff completion of the training.
- The service did not consistently communicate with clients GPs.
- Medical equipment was not regularly serviced and maintained. This meant there was a high risk of the equipment giving inaccurate information.
- A number of urine drug testing kits had passed their expiry date. Many were not stored in areas where staff could monitor the temperature. The test kits could therefore give inaccurate readings. Medicines were not stored at a safe temperature in line with the manufacturer's recommendations.
- The service had not developed a management plan to address actions following a Control of Substances Hazardous to Health (COSHH) assessment.
- The service had four members of staff working without references.
- We did not see any evidence of staff discussion around incidents involving clients and there was little discussion regarding future risk management and incident investigation findings.
- We did not see evidence of learning from incidents. Whilst some staff could describe examples of learning from incidents, others were unable.

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

- Staff had access to individual handheld panic alarms.
- All areas of the building were clean and well maintained.

Summary of this inspection

- The service had a policy in place for establishing safe starting doses for substitute medicines for clients known as titration.
- Staff had a good understanding of safeguarding adults and children and how to make an alert.
- Staff received debriefing following incidents.

Are services effective?

We do not currently rate standalone substance misuse services.

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

- Some staff did not receive supervision on a regular basis.
- Assessments of clients who received receiving psycho social interventions and who staff prescribed opiate substitutes were not comprehensive.
- Care plans were brief, had little information around clients' substance misuse and did not consider any social, housing or vocational needs.
- There was limited information about clients physical health needs.
- The service did not follow up clients who they referred for group programmes.

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

- The service provided treatment for alcohol withdrawal through an ambulatory detoxification programme. The service had a policy and procedure that described a client's suitability for the programme in line with NICE guidance.
- The service recorded client outcomes using the Treatment Outcome Profile (TOPs). The service measured outcomes when clients entered treatment and repeated this assessment every three months.
- Staff worked together and supported each other well to provide support, care and treatment to clients.
- There were no restrictions on anyone accessing the service.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff demonstrated a welcoming attitude to clients.
- Clients spoke positively about staff and described them as helpful.
- Clients could provide feedback to the service.

Summary of this inspection

- The service held a fortnightly service users meeting to discuss any issues in the service. The service user representative fed back to the management team.

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

- The service did not always record if they offered clients a copy of their care plan.

Are services responsive?

We do not currently rate standalone substance misuse services.

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

- Staff did not always follow their re-engagement policy with clients who did not attend appointments.
- The service complaints records did not have copies of formal written acknowledgements and responses to complainants.
- At the time of the inspection, information leaflets in the service were unavailable in other languages.

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

- The service had a reception area that was spacious and bright.
- Clients knew how complain about the service.

Are services well-led?

We do not currently rate standalone substance misuse services.

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

- The service did not have robust governance processes in place to provide assurance the service was operating effectively.
- Staff morale was poor. Some staff we spoke with felt that managers did not understand the demands and pressures that staff faced. Staff gave mixed responses about being able to raise concerns with management.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

- Training in the Mental Capacity Act (MCA) was not mandatory at the service. Staff we spoke with had a basic understanding of the MCA and its principles.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

- The service had a locked entrance. Staff on reception controlled access to the building through an intercom system and closed circuit television.
- The service had alarms which staff could use if the safety of staff or patients was at risk. The reception area had an alarm located at the front desk to summon assistance if activated. Staff had access to individual handheld panic alarms.
- The service had three clinic rooms. Both included an examination couch, weighing scales and a height measure. Staff used equipment to monitor the physical health of clients such as blood pressure machines, ear thermometers and electrocardiogram (ECG) machines. We checked if staff had calibrated the equipment and if they gave accurate readings. The service had calibrated the equipment; however, staff could not tell us whether the blood pressure and ECG machines had a service contract. The equipment should have a service contract to ensure they give accurate information.
- The service used a variety of testing kits for drug screens. We found that a number of urine drug test kits were out of date and many were not stored in area where staff could monitor the temperature. There was a risk the testing kits may have given inaccurate results in identifying clients health problems.
- All areas of the building were clean and well maintained. Alcohol gel was available and staff had taken the appropriate measures to reduce the risk of infection. The service had infection control and health and safety leads. Staff disposed of needles and other sharp objects in sharps bins. Hand washing posters were on the walls at sinks in the building. Staff gave clients injections and vaccinations at the service. Blood spillage kits were available.
- We reviewed the services fire risk assessment. At the time of the inspection, the fire risk assessment had two areas that required immediate action. A competent contractor needed to assess external fire escapes and fire exit doors needed to be changed. We informed the service manager of this, who after the inspection sent an updated fire risk assessment that confirmed they had undertaken the required actions. The service completed a Control of Substances Hazardous to Health (COSHH) assessment on the 25 November 2016. The assessment found asbestos in the building and whilst the service was investigating the issue, they had not taken actions or put management plan to address the issue.

Safe staffing

- The service was open 10-5pm on Mondays and Tuesdays, 12-7:30pm on Wednesdays, 10-7:30pm on Thursdays, 12-5pm on Fridays and 9-1pm on Saturdays.
- The service had an operations manager, a part time consultant psychiatrist, a service manager, three team leaders, eight recovery workers, a part time data officer, a part time receptionist and an administrator. The service had three nursing posts: a non-medical prescriber, an alcohol liaison nurse and a blood borne virus sexual health nurse. The service had vacant posts for a recovery worker and the three nursing positions. At the time of the inspection, agency staff covered two of the nursing posts. The blood borne virus sexual health nurse role remained unfilled. The two agency staff encompassed the responsibilities of blood borne virus sexual health nurse position into their roles.
- The service had many shifts requiring cover that went unfilled. In a three month period before the inspection

256 shifts required agency cover. Only 133 (52%) of these shifts were covered. In the last 12 months the service had a turnover of 47%. The service manager felt turnover was high due to transfers from the previous provider and the merge of prescribing and psycho social services. The service did not provide data relating to levels of sickness, however at time of the inspection four members of staff were on long term sickness.

- The current provider took over the service in October 2015. Since the takeover, the service had reviewed staffing levels. This led to a reduction in the number of staff in the service. After the inspection, the provider presented a model approved by commissioners that demonstrated how they had reorganised staffing levels.
- Caseloads for recovery workers averaged 50-60 clients each. The service determined caseloads based on the complexity of the client. Staff we spoke with had mixed views about the manageability of their caseloads. Some staff we spoke with did not feel that that staffing levels were safe since commissioners had approved the redesign of the service.
- When staff went on annual leave it was the staff's responsibility to find cover for key working and groups. Staff felt this was an additional stress to their workloads. At the time of the inspection, the consultant psychiatrist was on long term sick leave and the service had did not have a locum member of staff to cover the consultant's duties. However, the service had attempted to recruit a locum and the provider's medical director was covering the post and attended the service on a regular basis.
- During the week, staff could speak with a staff member who could prescribe medicines. At the time of the inspection this was the non-medical prescriber as the consultant was on sick leave.
- Staff had not completed the majority of their mandatory training. The service required staff to undertake learning and courses as part of their mandatory training. Of the 12 mandatory courses only three, safeguarding children levels three and five and health and safety risk assessments, had a completion rate above 75%. Fifty-nine-percent of staff had completed infection control training whilst only 50% of staff had undertaken naloxone administration, basic life support, anaphylaxis and automated external defibrillation training. The percentage was lower for equality and diversity (41%), health and safety overview (29%), information governance (35%) and bullying and harassment (0%). The service manager informed us that they had given staff a deadline of December 2016 to complete the training or it would become a performance issue. However, we did not feel this was a valid reason for the low percentage of mandatory training. It was the provider's responsibility to appropriately review training needs and ensure they support staff to participate.
- We reviewed staff records for recruitment references and disclosure and barring service (DBS) checks and determined that four staff out of 19 had missing recruitment references. After the inspection, the service informed us that they had received a first reference for all staff, with two receiving second references.

Assessing and managing risk to clients and staff

- The service required staff to undertake a comprehensive risk assessment with each client. The risk assessment consisted of a tick box screening tool that covered a range of potential risks including physical health, substance misuse and mental health. The assessment provided space for practitioners to include more detail. The service offered all clients blood borne virus testing for Hepatitis and HIV. We reviewed nine care and treatment records and the service had risk assessed the majority of clients. However the risk assessments were limited and omitted key information. Staff had not developed management plans for clients choosing to leave the service. For example, there was no information that advised clients of the potential increased risks of overdose from drugs or alcohol after a period of substitute prescribing.
- The service had a policy in place for establishing safe starting doses for substitute medicines for clients known as titration. Staff monitored withdrawal symptoms using validated withdrawal scales such as the clinical opiate withdrawal scales (COWS).
- The service did not consistently communicate with clients GPs and there was limited information about clients physical health needs. For example, there was no contact with a client's GP to confirm they were now prescribing to the client or any details around this. For another client, whilst there had been initial contact with their GP advising what the service had prescribed, when the service altered the dosage they did not inform the

GP. For clients undergoing alcohol detox, staff obtained appropriate blood tests, physical health checks and other information from the clients GP prior to starting the programme. The service's letter to the clients GP stated that they needed the tests and results due to the client undergoing an alcohol detox. The non-medical prescriber reviewed the test results prior to detox starting and raised any queries with the consultant psychiatrist. After completion of detox, the service a wrote to clients GPs advising them of completion and any medication they had prescribed as part of aftercare with a request for the GP to review and to continue prescribing if needed.

- Staff we spoke with had a good understanding of safeguarding adults and children, how to make an alert and were required to undertake safeguarding adults and children training. The majority of staff had completed this training. A safeguarding lead kept a record of all safeguarding referrals in a log that other staff updated to ensure they followed up referrals appropriately. In our review of care and treatment records, we observed that staff appropriately identified safeguarding concerns and alerted the local authority safeguarding team when necessary.
- The provider had a lone working policy for staff. When staff undertook home visits or outreach work they visited in pairs where possible or in conjunction with social workers.
- Staff did not always follow the service's policy to store, generate and issue prescriptions for controlled drugs and other medicines. Within a folder in the service's safe, we discovered large quantities of voided prescriptions that the service had not destroyed. We also found several blank prescriptions in a personal safe belonging to a member of staff. Staff we spoke with told us there were recent incidents of individual prescriptions going missing. At the time of the inspection, the service had reported this to the chief pharmacist and this was currently under investigation. However, the service had not contacted the appropriate external authorities after the incident. After our inspection we advised the service of this and which authorities they needed to notify. According to the services policy, when staff accessed the safe, they were required to document the reason why. The records we reviewed had no explanations or documentation of reasons why staff accessed the safe. We asked staff why the number of voided prescriptions was unusually high and staff agreed that voided prescriptions were higher than would be expected. Staff should have returned completed prescription log forms with evidence of voided prescriptions before the service manager issued a new batch. The service's policy stated that the service manager must retain delivery notes for auditing purposes, and that they must document all voided prescriptions on the prescription log. The service had not logged several voided prescriptions and had not retained all delivery notes.
- We observed a prescription log sheet that showed the service had issued two prescriptions to the consultant psychiatrist without any client details. When we questioned this with the service, they informed us that when they requested the client details, the consultant psychiatrist could not remember them.
- The service had an approved formulary and staff generally prescribed within the service's formulary and opiate substitution guidelines.
- We saw records of room temperature monitoring for the clinical room where the service kept emergency medicines. We noted that temperature readings were consistently above 25°C, with a maximum reading of 32°C recorded in August 2016. This was above the manufacturer's recommendation which stated the medicine should not be stored above 25°C. This made the medicine potentially unsafe to administer to clients.
- The service did not store any controlled drug medicines on site. The service stored emergency medicines such as Epipen, Naloxone and Adrenaline in a clinical room used by the non-medical prescriber. Hepatitis vaccines were stored in the fridge. Fridge temperatures were within the recommended limits.
- At the time of our inspection all clients prescribed substitute medicines were subject to supervised consumption at the service. The provider was looking to develop systems to identify clients who were progressing with their treatment and had been stabilised for some time who may be suitable to switch to unsupervised consumption.

Track record on safety

- The service reported one serious incident requiring investigation in the previous year.

Reporting incidents and learning from when things go wrong

- The service used an electronic system to record incidents, monitor investigations and record outcomes and learning. Each incident had an allocated lead responsible for managing the investigation and learning process.
- Staff described how they had, or would, report a range of incidents. These included challenging behaviour from clients, and concerns about clients self-harming.
- Staff reported that they received feedback on incidents at multi-disciplinary and clinical governance meetings as well as through emails. However, records of team meetings did not include discussion of incidents. Whilst some staff could describe examples of learning from incidents, others could not.
- Staff received debriefing following incidents and had access to an employee assistance programme if they were affected by an incident.

Duty of candour

- Duty of candour is a legal requirement, which means providers must be open and transparent with clients about their care and treatment. This includes a duty to be honest with clients when something goes wrong. Staff were aware of the need to be open and transparent when things went wrong.

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

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

- Staff assessed clients when they first attended the service. At the time of the inspection the main consultant was on long term sick leave and an alcohol nurse who was also a non-medical prescriber was undertaking assessments and prescribing. The alcohol nurse was experienced and in the absence of the consultant was supervised by the medical director. The assessments were comprehensive and covered current and historical use of substances, physical health, mental health, criminal history, social functioning, sources of stress and social functioning. We looked at nine care and treatment records for clients using the service. For clients receiving psycho social interventions and prescribed opiate substitutes, the assessments we reviewed were brief and had limited information.
- Staff routinely assessed client's alcohol dependency using the Severity of Addiction Questionnaire (SADQ) in accordance with national guidance. The service obtained appropriate blood tests and other physical health checks and information from a client's GP prior to the detox starting. The alcohol nurse reviewed test results prior to the beginning of the programme and raised any queries with the medical director in the absence of the consultant. The comprehensive assessment also included an assessment of the client's home situation and any children they were parents to, or had regular access to. The alcohol nurse would not begin the detoxification programme until they were satisfied a family member/carer were able to provide appropriate support during the programme and understood what the role entailed. The family member/carer signed a document agreeing to support the client during the programme.
- For two clients receiving psycho social interventions, the assessment for one of the client's did not include information about their mental health. For both clients, staff had not included information about physical health. We discovered in the progress notes that one of the clients had told staff of a physical health ailment in a one to one session. Staff had not updated the assessment to reflect this. Whilst the risk was minimised due to the fact that the service was not prescribing to these clients, it was still a concern and risk to patient safety.
- We reviewed four records of clients being prescribed opiates substitutes. One record showed that the client had recently been transferred from another provider. The service contacted the other provider for referral information and to confirm the client's prescription. The progress notes documented that staff had completed an assessment a week after the transfer of the client. The details of this assessment were not in the record. When we asked staff to find this file, they could not locate it.

For each of the other three clients, staff had completed a comprehensive assessment and this was available on the clients' record. However, one of these included a longstanding client of the service and the only comprehensive assessment available was dated in November 2016, despite the electronic record indicating they had been receiving treatment for at least 11 months prior. There was no evidence to indicate staff had comprehensively assessed the client prior to the commencement of their treatment.

- We reviewed nine care plans. Three clients had a "my recovery plan" which included clients views. However, they contained brief information, were not holistic and had little information around the client's substance misuse. The care plans did not consider any social, housing or vocational needs of the person and did not pull in any information gathered by the clinician during their assessments. Two records we reviewed demonstrated that there was little or no contact with the client's GP's.

Best practice in treatment and care

- The service had a policy for medicine prescribing written in accordance with national guidelines issued by the Department of Health.
- The service provided treatment for alcohol withdrawal through an ambulatory detoxification programme. The service had a policy and procedure that described a client's suitability for the programme in line with The National Institute for Health and Care Excellence National (NICE) guidance and which clients should be referred on for specialist inpatient detox. The service offered group work for community alcohol detoxification. This included recovery support group work for pre detox and aftercare. Staff discussed referrals for community detox in multi-disciplinary meetings and discussed concerns around suitability with the consultant psychiatrist and alcohol nurse. On each day of detox the client and carer attended the service to meet with the alcohol nurse. Staff undertook and recorded physical health checks and breathalysed each client. The client brought their medication with them and the alcohol nurse reviewed their administration and advised the client and carer on the medication administration regime until their next appointment the following day. They also reminded them each day of what to do in an emergency.
- Where clients were on high doses of medication, the service expected staff to arrange for them to have electro-cardiograms (ECG). We reviewed a client record that indicated the client required an ECG. Staff had not followed this up and had not taken any action to advise the GP of the need for an ECG. Whilst the service had an ECG machine, the service had not trained staff to use it. At the time of the inspection the client had still not had an ECG and staff had not identified who was going to take the lead in following this up.
- The service did not have a psychologist and would refer clients to a mental health service for psychological support. At the time of our inspection the service had plans to set up a joint working process with local mental health providers.
- Clients attended one to one sessions with key workers. Some clients attended group programmes. Recovery workers co-ordinated groups for clients. These included dependent and reduced drinkers groups, acupuncture, opiate detox groups and self-management and recovery training (SMART). NICE guidance recommends SMART recovery for treatment of alcohol misuse. However, the progress notes showed that none of the clients referred for group programmes had attended and staff had not followed up the reasons for this. The Department of Health guidance on drug misuse and dependence outlines the importance of substance misuse services utilising a range interventions and approaches to support clients in their recovery. It was unclear why the service focused on one to one interventions with clients, particularly when some of these clients could be classed as failing to benefit as they were using on top of their prescriptions.
- Staff supported clients in the service with employment, housing and benefits advice and assistance. Staff in the service addressed clients social care needs in addition to their treatment needs.
- The service recorded client outcomes using the Treatment Outcome Profile (TOPs). The service measured outcomes from when clients entered treatment and carried out a further assessment every three months. A final outcome measurement was undertaken when the service discharged clients from the service. The service also provided information to the National Drug and Treatment Monitoring Service (NDTMS).

Substance misuse services

- The services chief pharmacist conducted a prescribing audit every six months. This identified the type and dose of medicine prescribed to each client. The service could monitor that staff prescribed medicines in accordance with the provider's policy and national guidance. The service also undertook a fortnightly case file audits with staff and audits of safeguarding alerts.

Skilled staff to deliver care

- The service employed a consultant addictions psychiatrist who worked part time at the service. The doctor was a specialist in addictions and had experience of working with the client group.
- The service manager had experience in substance misuse services. Recovery workers had previously worked in substance misuse services.
- The service required staff to receive supervision on a monthly basis. We reviewed all staff files for evidence of 1:1 supervision with managers. From April 2016 to November 2016 only 68% of staff had received supervision. Some staff we spoke with felt they did not receive regular supervision. One supervisor said they had not received training on providing supervision and did not feel comfortable in doing this. All staff had received an appraisal.
- When staff did not perform to expected standards this was addressed. The service used informal and formal measures ensure staff recognised their responsibilities.
- Staff said they had completed an induction on commencing employment in the service. However, some staff said due to the extra workload they had no time to undertake additional training.

Multidisciplinary and inter-agency team work

- All staff attended a clinical team meeting each week. In the clinical meeting staff discussed new case presentations, applications for detoxification, safeguarding and discharges. The service held a separate team meeting each week where staff discussed criminal justice, blood borne testing, prescribing and health and safety. Staff had not regularly recorded the contents of these meetings. We did not see any evidence of staff discussion around incidents involving clients. There was little discussion regarding future risk management and incident investigation findings.
- Staff held briefings at the beginning of the day to discuss information such health and safety, clinic room checks, risk and safeguarding concerns.
- The service had links with a range of organisations. Staff attended multi-agency safeguarding hub (MASH) partnership meetings as well as child protection conferences for individuals open to services. The service was part of a domestic violence panel and had input into the management of offenders in integrated offender management services. The service wished to develop its links with mental health partnerships and a consultant from the local mental health provider had recently contacted the service in regards to dual diagnosis. Staff also worked with the police and had links into community safety and worked with police community support officers to do home visits.

Good practice in applying the Mental Capacity Act

- Training in the MCA was not mandatory at the service. Staff we spoke with had a basic understanding of the MCA and its principles.

Equality and human rights

- There were no restrictions on anyone accessing the service. Clients in the service had different ethnic backgrounds and were of different sexual orientation and ages. Clients with a disability were able to receive treatment at the service or at home. Clients in the service reported that they had not experienced discrimination based on their race or sexual orientation.

Management of transition arrangements, referral and discharge

- When clients were referred to the service from other substance misuse services, staff obtained details from the other service, including information regarding the client's prescription and potential risks. The service provided the same information to other services when clients moved out of the borough.

Are substance misuse services caring?

Kindness, dignity, respect and support

Substance misuse services

- During our inspection we observed interactions between staff and clients. Staff demonstrated a caring and welcoming attitude and treated clients with warmth.
- Clients spoke positively about staff and described them as helpful and accepting. They said that whilst their keyworker was not always available, another member of staff was available to help. However, clients said they often had to wait outside the entrance and at reception for longer than they wished due to a lack of staff at the reception desk.
- Overall, staff understood client needs. Staff were empathic to clients and supported them with a range of difficulties.
- The service asked clients to provide consent for the service to share information with other agencies, and had signed a consent form.

The involvement of clients in the care they receive

- Staff did not record whether they offered clients a copy of their care plan to refer to when away from the service. However the majority of clients we spoke with told us they had received copies of the care plan.
- The service held a fortnightly service users meeting to discuss any issues in the service. The service user representative fed back to the management team. The service had a feedback form in the reception area based on the NHS Family and Friends Test. Staff displayed outcomes on a "you said, we did" board in the reception area.
- The service provided formal groups for working with clients' relatives or friends and staff told us about individual support they provided to people.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Access and discharge

- Clients could refer themselves to the service. The service also received referrals from other referrers including GPs, mental health services and social services. In the previous year the service received 752 referrals, 61% of these were self referrals. The service allocated referrals within 24 hours and aimed to assess clients within two weeks of referral.
- The service monitored waiting times for assessments through its diagnostic and outcomes monitoring executive summary report. If clients waited over three weeks for an assessment, commissioners would raise this at the contract monitoring meeting.
- Clients who presented themselves to the service or required urgent treatment had access to an emergency assessment slot. Emergency assessment slots were available every day.
- The service assessed all people with a drug or alcohol problem. There were no exclusion criteria for the service. When clients requested detoxification from 'novel' drugs, such as gamma-butyrolactone, the service referred them on to a specialist service. The service would refer clients to inpatient detoxification if they suffered alcohol withdrawal seizures.
- At November 2016 the service had a total number of 478 clients on their caseload.
- At the time of the inspection, when clients telephoned the service they received a quick response.
- The service had a re-engagement policy that identified actions staff should take when clients did not attend appointments. Staff discussed re-engagement plans during assessments with clients and identified how they could contact clients. However, during our review of care and treatment records we identified a client who failed to attend an appointment and did not see any evidence that staff had followed this up. The service manager told us the client attended the service the next day for a follow up but could not clarify whether the service followed up the client or the client attended on their own.
- The service offered flexible appointment times to clients and was open till 7:30 pm, two evenings a week. Clients we spoke with said that staff did not cancel appointments.

The facilities promote recovery, comfort, dignity and confidentiality

Substance misuse services

- The service had a reception area that was spacious and bright. The service had recently lowered the desk to create a more inviting atmosphere. Clients we spoke with felt the waiting area was comfortable and the building was always clean.
- The service had interview rooms, group rooms, clinic rooms and areas for staff. There was adequate sound proofing between the rooms so that clients could speak with staff in these rooms and would not be overheard.
- A range of information was available for clients and included information on the care and treatment offered at the site, how to make a complaint and how to access advocacy services.
- The service encouraged clients who had stopped using drugs and alcohol to become peer mentors and volunteers.Staff supported and mentored clients with this process, enabling them to take on greater roles independently. The service had 16 volunteers to support clients with treatment, 13 of the volunteers acted as counsellors to provide ongoing support.

Meeting the needs of all clients

- Equality and diversity training was mandatory for staff and was an agenda item at the team's business meeting. However, at the time of the inspection only 41% of staff had completed this training.
- The local population was largely white British, with over 85% of clients identifying themselves as from this background. Staff felt that this was beginning to change and the population had begun to diversify. At the time of the inspection, information leaflets in the service were not available in other languages. However, staff told us they had recently ordered leaflets in different languages. Some of the staff at the service spoke several different languages and the service facilitated staff with clients who spoke the same language. The service also used an interpreter service where clients' first language was not English.
- The service offered specialist services for lesbian, bisexual, gay and transgender (LGBT) clients.
- Clients with restricted mobility or wheelchairs could access the service through a stair lift at the entrance. Toilets suitable for disabled clients were available. When clients could not attend the service due to their disability, staff conducted home visits.

Listening to and learning from concerns and complaints

- In the 12 months before the inspection the service had received six complaints. Themes in these complaints included access to the service and staff treatment towards clients. The service upheld all these complaints. The service had a complaints procedure and required the service manager to send an acknowledgement letter within 48 hours of receiving the complaint and a response letter within 28 days. Staff recorded complaints on the electronic incident reporting system. However, the complaints records did not have copies of formal written acknowledgements and responses sent to complainants. The management advised us that copies of the letters were stored in the clients care plan.
- Clients knew how to make a complaint about the service. The reception area had leaflets that gave advice to clients on how they could complain and clients felt confident to make a complaint.

Are substance misuse services well-led?

Vision and values

- The provider had defined visions and values for the service. However most staff we spoke with were unaware of the services values.

Good governance

- Westminster Drug Project (WDP) provides services to people affected by substance misuse across London and the South East of England and is a registered charity. The organisation had been managing the service in Havering since October 2015. The manager of the service in Havering reported to an operations manager. The charity's board of trustees had overall responsibility for the governance of the services.
- The manager at the service felt supported by senior managers and had the support to take decisions needed to make changes at the service. A non-medical prescriber signed off all prescriptions. At the time of the inspection, there was no consultant psychiatrist at the

service to supervise this. Some staff we spoke with felt the prescribing practice was unsafe. Staff had raised these concerns with the managers but thought their concerns were not taken seriously.

- Governance processes were weak in relation to investigating incidents, learning from incidents, ensuring staff supervision and mandatory training. During our inspection we reviewed recent incidents at the location. The service manager had not signed off incidents we reviewed and had not recorded actions for the service to take or demonstrated any learning for staff. As part of our inspection we reviewed all staff files for evidence of 1:1 supervision with managers. From April 2016 to November 2016 only 68% of staff had received supervision. The majority of staff had not signed to confirm they had completed their induction. Whilst staff said they had completed their induction, we did not see any records that could demonstrate this.
- The service assessed performance through key performance indicators (KPIs). For example, the successful completions of drug (opiate and non-opiate) and alcohol treatment as a proportion of the total treatment population. The service completed a monthly contract monitoring report for commissioners to review performance. The service manager attended a number of meetings in relation to the governance and performance of the service. These included contract monitoring with commissioners, integrated governance meetings, mortality reviews, managers meetings and facilities working groups.

Leadership, morale and staff engagement

- The provider had undertaken a staff survey that included the service. However, the results were not available at a service level.
- Sickness and absence levels at the service were high. We did not received data on sickness levels but managers told us that four staff were on long term sick leave.
- Staff knew the providers whistleblowing procedure but gave mixed responses about whether they felt confident in raising concerns with management. Some staff we spoke to felt the service had a blame culture and that senior managers were unaware of the challenges they faced under increasingly higher workloads.
- Staff morale was low and many staff were unhappy with the service since the provider had taken over in 2015. Staff highlighted the high turnover rate of staff and described it as unsafe due to being given consistently higher workloads. Clients we spoke with also highlighted the lack of continuity in recovery workers and were often not informed that they had a new recovery worker.
- Staff we spoke with felt the team they worked in were supportive of each other. Staff worked together to provide support, care and treatment to clients.
- Staff we spoke with did not feel able to provide feedback to the management team or that they would listen to ideas for service improvement.

Commitment to quality improvement and innovation

- The service had begun to implement a service development plan. This would identify what the service is working towards, improving in house training and service user involvement.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure staff follow the service policy to safely store, generate and issue prescriptions for controlled drugs and other medicine.
- The provider must ensure there are sufficient staffing levels that meet the needs of clients.
- The provider must ensure that potential risks to clients and others are assessed appropriately. Clients must have risk management plans addressing identified potential risks and unplanned exits from the service.
- The provider must ensure that staff complete the mandatory training.
- The provider must ensure regular communication and information sharing with client GPs.
- The provider must ensure staff receive regular supervision.
- The provider must ensure systems and processes are operated effectively to monitor and improve the quality of safety of services including learning from incidents, training, supervision and risk management.

Action the provider SHOULD take to improve

- The provider should ensure that actions identified by health and safety risk assessments are completed within the required date.
- The provider should ensure medical equipment is regularly maintained to ensure accurate readings.
- The provider should ensure they undertake appropriate recruitment processes for staff working at the service.
- The provider should ensure that all clients have a comprehensive, detailed, assessment and care plans that are holistic and personalised. Assessments should identify client's physical health, educational and social needs.
- The provider should ensure clients are offered a copy of their care plan.
- The provider should ensure staff utilise a range of interventions and approaches to support clients in their recovery.
- The provider should ensure that all complaints about the service are documented appropriately. Clients who complain should receive a written response including how they can appeal against the complaint response and learning from complaints should be shared with the staff team
- The provider should ensure they foster appropriate staff engagement.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure that potential risks to clients were appropriately assessed. Clients did not have risk management plans relating to unplanned exits. **This was a breach of Regulation 12 (2)(b)** The registered person did not ensure that medicines were safely managed. Staff did not always follow the service policy to store, generate and issue prescriptions for controlled drugs and other medicines. Medicines were not stored at a safe temperature or in area where staff could monitor the temperature. The service did not take appropriate action to notify required authorities of an incident involving missing prescriptions. A number of urine drug test kits had expired and many were not stored in area where staff could monitor the temperature. **This was a breach of Regulation 12(2)(g)** The provider did not ensure they had appropriate arrangements to share relevant information consistently and promptly with clients GPs. **This was a breach of Regulation 12(2)(I)**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have systems and processes to appropriately govern the service.

This section is primarily information for the provider

Requirement notices

The service did not have evidence of learning from incidents and we did not see evidence of investigations or response letters to complaints.

This was a breach of Regulation 17 (2)(1)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to ensure they met clients care and treatment needs. The service had staffing vacancies and although used agency staff, shifts went unfilled. Staff had high caseloads averaging between 50-60 clients. **This was a breach of Regulation 18 (1)** The provider did not ensure staff completed their mandatory training. Staff should be supported to make sure they can participate in mandatory training as defined by the provider. All learning and development and required training should be monitored and appropriate action taken quickly when training requirements are not met. Staff did not receive appropriate ongoing or periodic supervision in their role to make sure competence was maintained. **This was a breach of Regulation 18 (2)(a)**