

Westminster Drug Project

WDP Harrow

Inspection report

44 Bessborough Road
Harrow
HA1 3DJ
Tel:
www.wdp.org.uk

Date of inspection visit: 2 November 2022
Date of publication: 02/02/2023

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, 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 to people's needs?	Good	
Are services well-led?	Good	

Summary of findings

Overall summary

WDP Harrow is a community-based drug alcohol service. This is the second time that the service has been inspected by the Care Quality Commission. We first inspected this service in May 2018 but did not rate them at the time.

We rated this service as **good** because:

- The service provided safe care. The number of clients on the caseload of the team was not too high to prevent staff from giving each client the time they needed. Staff demonstrated a good understanding of the risks associated with substance misuse and individual client risks. Staff responded promptly to any sudden deterioration in a client's health. Staff assessed clients physical and mental health prior to commencing any detoxification treatment.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable for clients needing treatment for substance misuse and in line with national guidance about best practice.
- The team had access to the full range of specialists required to meet the needs of clients receiving treatment for drug and alcohol misuse. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and relevant services outside the organisation. Staff effectively supported clients to access a local hepatitis C clinic to ensure early detection and treatment of the virus. The service had a partnership with the local hepatology team, whereby clinicians offered liver function testing and then screened clients for referral into the hepatology pathway.
- Staff treated clients with compassion and kindness and understood the individual needs of clients. They actively involved clients in decisions and care planning. Clients fed back positively about the staff and the service they received. The service had strengthened the Capital Card Scheme, which provided rewards to help motivate clients to attend health and wellbeing appointments.
- The service was easy to access. Staff planned and managed discharge well and had alternative pathways for people whose needs it could not meet. Staff responded to high risk clients by effectively transferring them to inpatient detoxification services.
- The service aimed to support people in harder to reach communities through participating in community events and online conferences. The service recognised some clients were vulnerable and isolated when the service was closed. Therefore, it had subcontracted with another local organisation to provide safe weekend activities.
- The service was well led, and the governance processes ensured that its services ran smoothly. Staff felt respected, supported and valued by colleagues and managers. The governance structure, information from audits and senior management meetings, and the quality of the service improvement projects demonstrated that leaders understood the needs of the client group and delivered services to meet them.

However:

- Client's records were not always kept up-to-date. Staff did not always ensure they uploaded the clients' medicines record from the GP before they commenced treatment.
- Whilst governance processes operated effectively at team level, improvements were still needed. Audits had not included whether GP summary letters were uploaded onto the system when they were received in a timely way.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community-based substance misuse services	Good 	



Summary of findings

Contents

Summary of this inspection

Background to WDP Harrow

Page

5

Information about WDP Harrow

6

Our findings from this inspection

Overview of ratings

7

Our findings by main service

8

Summary of this inspection

Background to WDP Harrow

WDP Harrow provides advice, support and treatment to adults and families with drug and alcohol problems in Harrow. It is commissioned by the London Borough of Harrow. This is a recovery service delivered by WDP Harrow in partnership with other community organisations. The service came into being on 31 January 2017. The service provides abstinence-based therapy, access to prescribing and community detoxification, group work, and support for family and carers. The service currently supports about 450 clients.

The service had expanded and was receiving more referrals. The managers were in the process of securing new building facilities to accommodate the staff and clients.

WDP Harrow is registered to carry out treatment of disease, disorder or injury. There is a Registered Manager in post. This is the second time that the service has been inspected by the Care Quality Commission. We first inspected this service in May 2018, and we did not rate them at the time.

What people who use the service say

We gathered feedback from 8 clients who used the service. Clients said staff treated them well and behaved kindly. Clients described it as a friendly, welcoming place. One client said they treat them like 'human beings.' Another said that the staff support is invaluable. A third client said that the staff are good at listening, were non-judgmental and very encouraging in their recovery journey. A client described how the doctor 'saved their life' and went above and beyond.

Clients reported that staff explained to them their treatment plan, especially their medicines. One client stated that staff explained their dosage of medicines and the plans to decrease this over time. All clients reported that staff obtained their consent about whether they wanted their family involved in their care and treatment.

One client reported that staff had referred them to the local mental health team for trauma therapy and this was helping. Another client described how staff had 'fast tracked' them into detoxification treatment.

Seven clients reported that they were involved in the planning of their care and treatment. Two clients reported they were given a copy of their care plan and a further two clients reported they knew about their care plan if they wanted a copy.

Three clients reported that they had given feedback about the service. This feedback was via the monthly service user's forum or through the service user feedback forms. The service had a device set up in the waiting area for clients to give real time feedback. Between January – October 2022 363 clients had provided feedback this way whilst attending their appointment. Fifty percent of these clients said they had received excellent care on their visit. Most of the negative feedback was regarding waiting times and better communication when appointments were running late. Some clients fed back that they would like refreshments, including hot drinks and snacks in the waiting area. The service already provided hot drinks to clients waiting. The service was planning to expand the Capital Card scheme by installing a 'grab and go' cabinet, which will contain non-perishable food. The clients would be able to redeem this food with their capital card points.

Summary of this inspection

How we carried out this inspection

The team that inspected the service comprised of three CQC inspectors and one specialist advisor with a specialist in addictions.

During this inspection, the inspection team:

- visited the service and observed the environment and how staff were caring for clients
- spoke with the registered manager
- spoke with 11 staff including the service manager, area director, clinical lead and the recovery practitioners
- spoke with 8 clients
- reviewed 7 clients' care and treatment records
- observed an alcohol detoxification appointment
- reviewed prescribing and the medicines prescription process
- reviewed other documents concerning the operation of the service.

You can find information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

Outstanding practice

We found the following outstanding practice:

- Staff recognised that some clients found it difficult to engage in treatment. Staff had responded with the Capital Card Scheme, which had been in place since 2018. Staff had developed this project in consultation with clients. Clients received plastic cards, which were topped up with points each time they attended a group or clinic. Clients could then redeem these points at selected local businesses offering health or wellbeing services, such as the gym or cinema. Since the last inspection, staff had updated the scheme to include blood borne virus (BBV) testing and eye testing at the local clinic.
- The service had a partnership with the local hepatology team, whereby clinicians offered liver function testing and then screened clients for referral into the hepatology pathway.

Areas for improvement

Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

- The service should ensure that staff upload GP summary letters to clients records as soon as they are received.
- The service should continue to embed governance arrangements so that auditing and monitoring of client care records is robust.






Our findings

Overview of ratings

Our ratings for this location are:

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

We rated safe as good.

Safe and clean environment

All premises where clients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. Staff completed a fire risk assessment every 6 months in September 2022 and staff took part in fire drills twice a year, to ensure safe evacuation. The premises had fire extinguishers to ensure the safety of staff and clients in case of a fire.

All interview rooms had alarms and staff available to respond. Clients and visitors signed in and out at reception. Interview rooms were fitted with alarms for staff and clients to summon support in an emergency. Staff also had personal alarms to use on other parts of the building. Staff tested alarms weekly. Parts of the building, where only staff were allowed access, had key card swipe access fitted to the doors.

All clinic rooms had the necessary equipment for clients to have thorough physical examinations. Staff made sure equipment was well maintained, clean and in working order.

All areas were clean, well maintained, well-furnished and fit for purpose. Due to the increase in service demand and an increasing workforce the building premises did not have enough clinical and office space to meet this demand. The service was currently looking for a bigger space to relocate to.

Staff made sure cleaning records were up-to-date and the premises were clean. The service contracted professional cleaning staff to clean the premises. Professional cleaning staff maintained records of when they had cleaned the premises.

Staff followed infection control guidelines, including handwashing. Staff disposed of sharps waste appropriately. Removal of clinical waste was collected by an appropriate external company. Staff wore the correct personal protective equipment, such as gloves, when carrying out urine drug screening. The service had a blood spillage fluid kit.

Community-based substance misuse services

Safe staffing

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

The service had enough nursing and support staff to keep clients safe. The number and grade of staff matched the service's staffing plan. The service had an establishment of 33 staff members altogether. The team consisted of recovery practitioners, team leaders, a clinical lead (specialty doctor), a nurse medical prescriber, a dual diagnosis nurse and criminal justice workers. In addition, the service had a full-time administrator to support staff with appointments and answering the telephones.

The service had 10 vacancies at the time of the inspection. These were for three recovery practitioners, a dual diagnosis practitioner and a senior harm reduction practitioner. The service used locum staff to cover some of the vacant posts. The manager had recruited 4 locum staff to help provide longer term cover for the vacancies. The posts for the recovery practitioner roles had gone out to advertisement and going through the recruitment process. Two new posts had been created through additional funding, a black and minority ethnic (BAME) outreach practitioner and a senior harm reduction practitioner. At the time of the inspection, a nurse medical prescriber had been recruited and was undergoing their induction training. Staff identified that recruitment in Harrow had been a challenge particularly in probation and social services. The service was focusing on joint recruitment with neighbouring services to ensure safe staffing.

The team caseload was 450 at the time of the inspection. Recovery practitioners had individual caseloads of around 40 clients. Staff said their individual caseload was manageable. Recovery practitioners carried out non-medical assessments, provided key work sessions, telephone follow up appointments and saw clients in an emergency when they were on duty. The doctor assessed clients, including medical reviews, prescribed medicines and completed clinical decisions. The administrator booked appointments and managed the telephone system.

Sickness levels were low. Managers planned to cover staff sickness and absence.

The service ensured robust recruitment processes were followed. We looked at the staff records for three staff working at the service. Each staff member had an up-to-date criminal record check to ensure they were safe to work with vulnerable adults. New staff provided valid references to ensure suitability for employment.

The service had recently received extra funding to recruit into new roles. These new roles were one full time black, Asian and minority ethnic (BAME) outreach worker and a senior harm reduction practitioner.

The service employed enough medical staff. The service had 1 doctor, employed by the provider full time. The doctor worked three days a week carrying out clinical duties at the service and the other two days working within clinical governance for the provider. The clinical lead had a high caseload of medical reviews. However, a new nurse medical prescriber had started the week of the inspection, and it was planned they would ease the caseload of the clinical lead.

Managers could use locums when they needed additional support or to cover staff sickness or absence. Managers made sure all locum staff had a full induction and understood the service. The service could get support from a psychiatrist when they needed to.

Community-based substance misuse services

Mandatory training

The mandatory training programme was comprehensive and met the needs of the client group. Staff had completed and kept up to date with their mandatory training. Compliance with mandatory training was 90%. Staff completed 19 mandatory training courses. Mandatory training included first aid, fire safety, infection prevention control and data security. Clinical staff were required to complete basic life support, defibrillator and manual handling training to support them in their roles.

Managers monitored mandatory training and alerted staff when they needed to update their training. The team leader informed staff when they needed to attend training and organised this on their behalf.

Assessing and managing risk to clients and staff

Staff assessed and managed risks to clients and themselves well. 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.

Assessment of client risk

Staff completed risk assessments for each client on arrival. We reviewed the risk assessments of 7 clients using the service. Staff used a recognised tool, and reviewed this regularly, including after any incident. Staff screened for common risks such as injecting history, risks associated with children and blood borne virus status.

Staff completed risk assessments with clients during their initial contact with the service and updated them whenever new information became available. Staff paid attention to potential risks to any children the client was in contact with.

Management of client risk

Staff demonstrated a good understanding of the risks associated with substance misuse and individual client risks. Staff discussed and reviewed high risk clients in the weekly multidisciplinary team meetings and during daily team handover meetings.

Staff responded promptly to any sudden deterioration in a client's health. Staff assessed clients physical and mental health prior to commencing treatment. Staff ordered baseline blood tests to assess whether a client could safely undergo an alcohol detoxification at home.

Clients received medication assisted therapy. Medication assisted treatment involved the use of medicines, in combination with other treatments such as counselling and group therapy. The service was expected to complete a medical review for each client under medication assisted treatment every 6 months, as opposed to annually in line with national guidance. At the time of inspection, staff had completed 97% of client medical reviews within 6 months. Three clients had received their medical reviews by the end of October and the remaining 2 clients had scheduled appointments alongside their prescription collection. The service was meeting the national target of seeing 99% of clients for a medical review in the last 12 months.

Staff offered opioid detoxification to clients. Staff described the risks of accidental overdose to the client due to loss of opioid tolerance during a detoxification. The doctor offered buprenorphine as treatment for an opioid detoxification. Records showed staff completed the Clinical Opiate Withdrawal Scale (COWS) tool when they assessed clients. Use of these tools to assess clients' withdrawal followed best practice guidance.

Staff shared information with GPs effectively. Staff contacted each clients GP on admission and used this information to help commence treatment.

Community-based substance misuse services

Staff recognised and responded to warning signs and deterioration in clients' physical health. We reviewed 2 clients records who had undergone a community alcohol detoxification. Staff recorded that the client attended the clinic each day for the first 5 days. The doctor or nurse completed the clinical institute withdrawal assessment for alcohol (CIWA-Ar) each day. This was a clinical assessment for staff to escalate any physical health concerns, such as nausea, tremors and sweating and ensures the safety of the client.

Prior to commencing treatment, the doctor referred the client for baseline blood tests at the clients GP. These baseline blood tests included a full blood count and liver function tests. This helped to assess whether the client could safely undergo an alcohol detoxification at home.

The service had a protocol for staff to follow when a client underwent a community alcohol detoxification. The protocol identified who could be safely detoxed at home. Staff excluded clients who were too high risk to commence a detoxification at home. This included people who were pregnant, had a history of delirium tremens, had a history of seizures or not able to follow up. Staff ensured that the client had a relative or friend with them throughout the duration of the detoxification to provide support. During the alcohol detoxification the doctor met with the client at the clinic every day for the first five days and then again on day 7 depending on their CIWA-Ar score. This meant the client could be monitored closely and any concerns could be escalated in line with national guidance.

Staff continually monitored clients on waiting lists for changes in their level of risk and responded when risk increased. Whilst the service did not have a waiting list to start treatment at the service, staff did monitor those clients that they had referred for inpatient rehabilitation treatment and were waiting to be admitted.

Staff could recognise when to develop and use crisis plans and advanced decisions according to client need. Records included plans for unexpected exit from treatment. Staff explained the risks to clients if they left treatment early. Staff followed the provider's policy to ensure clients did not leave treatment early, such as attempts to contact them via the telephone, email or text message.

Staff followed clear personal safety protocols, including for lone working. Staff used alarms when seeing clients in the office. For new clients, staff visited their homes in pairs to ensure their personal safety.

Safeguarding

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.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up to date with their safeguarding training. At the time of the inspection, all staff had recently received training in safeguarding vulnerable adults and children.

Staff knew how to recognise adults and children at risk of or suffering harm. Staff gave examples of how they had involved the local authority, the police and other agencies when they raised safeguarding concerns. Staff knew how to safeguard children and assessed clients who were in contact with children whilst receiving treatment.

Staff knew how to make a safeguarding referral. The service had an electronic safeguarding register, on which staff recorded adults at safeguarding risk and clients with children who had been identified as being at risk. Staff monitored the register monthly and updated it each time there was a change in safeguarding circumstances. Staff attended monthly safeguarding meetings to discuss the clients where they had made a safeguarding referral.

Community-based substance misuse services

Staff regularly attended multi-agency safeguarding meetings at the local authority to protect clients and children from abuse. The safeguarding families practitioner attended multi-agency risk assessment conferences as part of their adult social work role.

Staff access to essential information

Staff kept detailed records of clients' care and treatment. Records were clear and easily available to all staff providing care. However, client's records were not always to date.

Client notes were comprehensive, and all staff could access them easily. However, client's records were not always to date. In 2 out of 6 records we looked at, staff had not uploaded a copy of the client's GP summary letter to refer to. In one record, staff had requested and received the GP summary, however there was a delay in uploading it to the records. In the second record, the client was of no fixed abode and had been transferred from another service on medication assisted treatment. This client did not have a GP.

Staff used electronic systems to document client care and treatment records. Records were stored securely. Staff could only access the records by entering a personal username and password.

When clients transferred to a new team, there were no delays in staff accessing their records.

Medicines management

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 mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. Staff stored and managed all medicines and prescribing documents safely. The provider had arrangements in place for the safe management and control of prescription forms in line with national guidance. Staff kept accurate records of the use of controlled stationery to prevent diversion and illicit supply of medicines. Access to medicines storage areas was appropriately restricted. The service kept a supply of controlled medicines onsite.

Staff completed medicines records accurately and kept them up-to-date. We checked the medicine administration records for 6 of the clients receiving monthly buprenorphine injections and Vitamin B injections. Staff kept clear records of when they administered buprenorphine injections and medicines to assist with alcohol detoxification. If a client tested positive for hepatitis B, nurses were able to administer the hepatitis B vaccine on site via a Patient Group Direction (PGD). A PGD allows specified health professionals to supply and/or administer medicine without a prescription or an instruction from a prescriber.

Staff reviewed each client's medicines regularly and provided advice to clients and carers about their medicines. Staff actively encouraged clients to use naloxone and have access to it. Clients were provided with information on how to use it. Staff stored and managed medicines in line with the provider's policies.

Staff followed national practice to check clients had the correct medicines when they were admitted, or they moved between services. Staff reconciled clients' medicines before they commenced treatment.

Staff learned from safety alerts and incidents to improve practice. The pharmacist completed medicines audits to help improve medicines management. We looked at the audit for the period November 2021 to July 2022. The service had reported five incidents related to medicines.

Community-based substance misuse services

Staff reviewed the effects of each client's medicines on their physical health according to NICE guidance. Staff carried out urine drug screening on clients at regular intervals. The doctor recommended clients take vitamins when they underwent alcohol detoxification. Staff referred clients to other services for blood borne virus tests before they commenced treatment. ECGs were performed on clients who met the relevant criteria and in accordance with national guidance.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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.

Staff knew what incidents to report and how to report them. Between May and October 2022 staff had reported 13 incidents. These included medicines incidents, violence and aggression, death of service users and incidents related to information governance. The service had no never events.

Staff reported serious incidents clearly and in line with the service's policy. Thirteen clients using the service had died within the previous 12 months. None of these deaths were related to the treatment being provided by the service. Managers investigated these deaths and implemented improvements when needed.

Staff understood the duty of candour. They were open and transparent and gave clients and families a full explanation when things went wrong. Staff communicated with family, when needed, about serious case reviews.

Managers debriefed and supported staff after any serious incident. Staff said they received de-briefs after a serious incident and could have time to reflect as a team.

Managers investigated incidents thoroughly. Clients and their families were involved in these investigations. Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to client care. A key learning event in November 2022 identified 9 areas of improvement and themes from death reviews. These included improved recording of client re-engagement plans and joint discussions with mental health and dual diagnosis. Staff identified further learning from other incidents, such as, ensuring that some clients are followed up at home rather than just through telephone calls.

Managers shared learning with their staff about incidents that happened elsewhere.

Are Community-based substance misuse services effective?

We rated effective as good.

Community-based substance misuse services

Assessment of needs and planning of care

Staff completed comprehensive assessments with clients on accessing the service. They worked with clients to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.

We reviewed 7 care and treatment records. Staff completed a comprehensive mental health assessment of each client. Assessments covered a client's history of drug and alcohol use, social needs, physical health, and mental health needs. Staff also included details about clients' families and dependences. Staff ensured that assessments were carried out face to face with the client.

Staff made sure that clients had a full physical health assessment and knew about any physical health problems. Staff carried out physical health observations with clients before commencing treatment. These included blood pressure, height, and weight. Staff carried out ECGs on the clients at the premises and gave them the results. This helped inform treatment plans for the client.

Staff developed a comprehensive care plan for each client that met their mental and physical health needs. Staff regularly reviewed and updated care plans when clients' needs changed. Care plans were personalised, holistic and recovery oriented. Staff clearly recorded client's perspectives and objectives and what they wanted to achieve from treatment and recovery. Staff updated care plans regularly and when there needs changed. For example, when there has been a change in medication or treatment pathway such as an inpatient detoxification. Client goals included interventions such as support with their employment, attending group sessions and housing support.

Best practice in treatment and care

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 provided a range of care and treatment suitable for the clients in the service. The team worked with clients to reduce health and other problems related to drug misuse. Staff provided clients with psychosocial interventions to support them in their recovery. Interventions addressed reducing harmful or risky behaviours associated with the misuse of drugs, optimising personal physical and mental wellbeing, and achieving specific personal goals. Staff carried out urine drug screen testing to detect the illicit use of non-prescribed opiates. In addition, staff carried out breath alcohol content tests on clients undergoing alcohol detoxification. This ensured clients were monitored appropriately.

Staff recognised that some clients found it difficult to engage in treatment. Staff had responded with the Capital Card Scheme, which had been in place since 2018. Staff had developed this project in consultation with clients. Clients received plastic cards, which were topped up with points each time they attended a group or clinic. Clients could then redeem these points at selected local businesses offering health or wellbeing services, such as the gym or cinema. Since the last inspection, staff had updated the scheme to include blood borne virus (BBV) testing and eye testing at the local clinic.

Staff delivered care in line with best practice and national guidance from relevant bodies such as NICE. The service provided care and treatment based on national guidelines. Staff showed awareness of the Drug Misuse and Dependence: UK guidelines on clinical management (known as the 'Orange Book').

Community-based substance misuse services

Staff made sure clients had support for their physical health needs, either from their GP or community services. BBV testing was routinely offered to clients at the point of assessment. Clients had access to a hepatitis C team, who regularly attended the service to carry out physical health screens. The nurse administered hepatitis B vaccinations for those clients that needed. The service had a partnership with the local hepatology team, whereby clinicians offered liver function testing and then screened clients for referral into the hepatology pathway.

Staff supported clients to live healthier lives by supporting them to take part in programmes or giving advice. The doctor carried out regular physical health checks on clients. Staff supported clients to reduce or quit smoking. The service employed a smoking cessation advisor to support clients with their smoking. Staff assessed all clients for their weight and height, whether they smoked or drank alcohol. The service ran a regular needle exchange clinic.

Staff used recognised rating scales to assess and record severity and outcomes. Staff followed structured assessments to determine the severity of clients' alcohol use, such as the alcohol use disorder identification test (AUDIT), the severity of alcohol dependence questionnaire (SADQ) and they used the clinical opiate withdrawal scale (COWs) to assess opiate withdrawal levels for clients who were under medication assisted treatment. The service looked at how many clients left the service with a successful treatment outcome. Staff used the Core 34 change recovery model to monitor the effectiveness of counselling services for the clients who used this.

Staff used technology to support clients. For example, staff used a portable monitor to carry out ECGs on clients in their home.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. This included audits of risk assessments, care plans, medication, prescriptions and health and safety. Staff acted on the results when needed and managers followed these actions.

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of clients under their care. 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.

The service had had experienced staff with the right skills to meet the needs of each client. These included recovery practitioners, a doctor, a non-medical prescriber, a dual diagnosis nurse, administrators, criminal justice practitioners, safeguarding family practitioner and education and employment workers.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the clients in their care, including bank and agency staff. Managers gave each new member of staff a full induction to the service before they started work. The induction included time for training, as well as shadowing activities within the service. A new staff member's caseload would steadily grow with their time at the service.

Managers supported staff through regular, constructive appraisals of their work. At the time of inspection, 92% of staff had received an appraisal within the last year.

Managers supported staff through regular, constructive supervision of their work. Staff received regular supervision. The provider required staff to receive supervision 9 times over a 12-month period. At the time of inspection 85% of staff received this level of supervision in the last 12 months. In addition, staff were able to access weekly clinical supervision from the provider's central clinical meeting.

Community-based substance misuse services

Managers made sure staff attended regular team meetings, such as business meetings, multidisciplinary meetings and leadership meetings. Managers ensured meetings minutes were shared with staff that could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. The provider had an online training database that staff could access if they wanted additional training to support them with their job role. Training courses included topics such as suicide prevention. All staff had completed specialist training in best practice in optimising opioid substitute treatment (BOOST). Six staff were registered onto the recovery competency framework qualification to support their personal development.

Multidisciplinary and interagency team work

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(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss clients and improve their care. We observed the weekly multidisciplinary team meeting. Staff demonstrated positive risk taking with clients to ensure their needs were met. This included discussions around re-engagement and physical health care.

Staff made sure they shared clear information about clients and any changes in their care, including during transfer of care. For example, a client had been transferred to an addictions service in the North of England after they moved. Staff ensured that they provided the service with an effective handover for continuity of care.

Staff had effective working relationships with other teams in the organisation. Service managers from each of the provider's services across the country came together each month to discuss any concerns, good practice and to share learning.

Staff had effective working relationships with external teams and organisations. These included GPs, pharmacies, local authority safeguarding teams, community mental health teams, and other service providers such as housing provider and probation services. Staff worked closely with the local NHS hospital to provide clinics to the clients at the service such as eye testing, hearing tests, phlebotomy and rapid blood borne virus testing.

Good practice in applying the Mental Capacity Act

Staff supported clients to make decisions on their care for themselves. They understood the service'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.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access.

Staff gave clients all possible support to make specific decisions for themselves before deciding a client did not have the capacity to do so. Staff ensured that clients had informed consent by giving them information about their treatment options and discussing it with them.

Community-based substance misuse services

Staff assessed and recorded capacity to consent clearly each time a client needed to make an important decision. Staff understood mental capacity and were aware of how substance misuse can affect capacity. Staff worked under the principle that capacity is always assumed and where they queried a clients' capacity this was discussed as a team. Records showed clients consented to their treatment and where staff queried capacity, they referred for a mental health assessment.

Are Community-based substance misuse services caring?

Good 

We rated caring as good.

Kindness, privacy, dignity, respect, compassion and support

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.

We gathered feedback from 8 clients who used the service. Clients said staff treated them well and behaved kindly. Staff gave clients help, emotional support and advice when they needed it. Clients described it as a friendly, welcoming place. One client said they treat them like 'human beings.' Another said that the staff support is invaluable. A third client said that the staff are good at listening, were non-judgmental and very encouraging in their recovery journey. A client described how the doctor 'saved their life' and went above and beyond.

Staff supported clients to understand and manage their own care treatment or condition. Clients reported that staff explained to them their treatment plan, especially their medicines. Staff regularly reviewed the treatment plan with clients. For example, one client stated that staff explained their dosage of medicines and the plans to decrease this over time. All clients reported that staff obtained their consent about whether they wanted their family involved in their care and treatment.

Staff directed clients to other services and supported them to access those services if they needed help. One client reported that staff had referred them to the local mental health team for trauma therapy and this was helping. Another client described how staff had 'fast tracked' them into detoxification treatment.

Staff understood and respected the individual needs of each client. We observed staff interacting with clients in a thoughtful way. Staff provided emotional support to clients to minimise their distress. We observed a client's medical appointment and saw that the staff member knew the client well.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards clients and staff.

Involvement in care

Staff involved clients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that clients had easy access to additional support.

Community-based substance misuse services

Involvement of clients

Staff involved clients and gave them access to their care plans. Seven clients reported that they were involved in the planning of their care and treatment. Two clients reported they were given a copy of their care plan and a further two clients reported they knew about their care plan if they wanted a copy. Staff made sure clients understood their care and treatment (and found ways to communicate with clients who had communication difficulties).

Staff involved clients in decisions about the service, when appropriate. Three clients reported that they had given feedback about the service. This feedback was via the monthly service user's forum or through the service user feedback forms.

Clients could give feedback on the service and their treatment and staff supported them to do this. The service had a device set up in the waiting area for clients to give real time feedback. Between January – October 2022 363 clients had provided feedback this way whilst attending their appointment. Fifty percent of these clients said they had received excellent care on their visit. Most of the negative feedback was regarding waiting times and better communication when appointments were running late. Some clients fed back that they would like refreshments, including hot drinks and snacks in the waiting area. The service already provided hot drinks to clients waiting. The service was planning to expand the Capital Card scheme by installing a 'grab and go' cabinet, which will contain non-perishable food. The clients would be able to redeem this food with their capital card points.

Involvement of families and carers

Staff informed and involved families and carers appropriately. Care plans showed where staff had engaged with client's families to provide them with support. Records showed staff involving families in their loved one's care and treatment. For example, clients having the support of a close friend or relative during their alcohol detoxification as required.

Staff helped families to give feedback on the service. The service employed a family worker who led on supporting clients with their social circumstances, including working with their family.

Are Community-based substance misuse services responsive?

We rated responsive as good.

Access and waiting times

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.

The service had clear criteria to describe which clients they would offer services to. The service accepted referrals from anyone living in the borough of Harrow, and clients could self-refer.

The service met the service's target times for seeing clients from referral to assessment and assessment to treatment. The service aimed to contact clients within one week from referral and two weeks to assessment. As of November 2022, there was 30 clients waiting 4 weeks for their initial assessment. The managers aimed to analyse why clients had waited 4 weeks to be seen. Of these, 24 were delayed due to clients missing or cancelling their appointments. The remaining 6 had been assessed.

Community-based substance misuse services

Staff saw urgent referrals quickly. At the point of referral, the duty worker reviewed and then allocated all referrals to a member of staff for contact and assessment. All referrals were reviewed twice a week by the manager to ensure they have been allocated correctly and contact attempted. For those clients that needed to be seen or contacted the same day, the duty worker ensured this was facilitated.

The service did not have a wait list as all clients were allocated to a member of staff at the point of referral. However, staff did monitor those clients who were awaiting an inpatient detoxification and rehabilitation service. During the inspection, staff described that there was a wait to access inpatient rehabilitation after clients had completed their detoxification. Clients were at a higher risk during this time, so staff ensured that they monitored them regularly.

Staff tried to contact people who did not attend appointments and offer support. The service had a did not attend policy in place, which guided staff to the best approach when a client did not attend their appointment. Staff discussed those clients who were hard to engage in their weekly multi-disciplinary meeting. Care records showed re-engagement plans were in place. Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services.

Clients had some flexibility and choice in the appointment times available. The service offered two late clinics a week for those clients with family or employment commitments. Staff arranged appointments based on when the client could meet.

Staff worked hard to avoid cancelling appointments and when they had to, they gave clients clear explanations and offered new appointments as soon as possible. Six clients we spoke to, said that staff did not cancel appointments. When a staff member was off sick or could not make the appointment, staff sought alternatives to meet the client's needs. Appointments ran on time and staff informed clients when they did not.

Staff supported clients when they were referred, transferred between services, or needed physical health care. For example, staff had liaised closely with the local acute hospital to support a client who had chronic obstructive pulmonary disease. Staff worked with the hospital during the client's admission and afterwards when they were recovering at home.

The number of discharges was monitored by managers and discussed with staff at the monthly team meetings. The service had been working on reducing their caseloads, which had an emphasis on ensuring those who were ready for discharge were supported through this process. The staff we spoke to reported the barrier for timely discharges was rising caseloads and workloads.

The facilities promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported clients' treatment, privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care. The service had rooms for clients to meet with the doctor or key worker on the premises. The reception area welcomed clients and had comfortable furnishings whilst clients and visitors waited for appointments. The site also had an accessible toilet for clients to use to produce urine drug screen. However, all staff reported that the building was too small to accommodate all clinics and client appointment comfortably. Managers were aware of this and in the process of looking for alternative premises. At the time of the inspection, the business case for a bigger premise had been successful and the managers were progressing with finding a suitable building.

Interview rooms in the service had sound proofing to protect privacy and confidentiality.

Community-based substance misuse services

Meeting the needs of all people who use the service

The service met the needs of all clients, including those with a protected characteristic or with communication support needs.

The service could support and adjust for people with disabilities, communication needs or other specific needs. The service was accessible for clients using wheelchairs and clients with other mobility needs.

Staff made sure clients could access information on treatment, local service, their rights and how to complain. Interpreters were available for clients who did not speak English. The service had information leaflets available in languages spoken by the clients and local community.

The service recognised some clients were vulnerable and isolated when the service was closed. Therefore, it had subcontracted with Build on Belief (BoB) to provide safe weekend activities.

Staff supported clients with their employment and education. The service employed an educational and employment coordinator to support clients get back into employment or register with an educational institute.

Staff demonstrated an understanding of the potential issues facing vulnerable groups. For example, lesbian, gay, bisexual and transgender plus (LGBT+), ethnic minorities, pregnant women and older people. Staff were able to support LGBT+ clients with a dedicated approach and pathway. The service had created a new role after receiving some additional funding. This new role will involve being co-located at a local third sector community safe space hub to reduce health inequalities. The staff member will focus on supporting people with their mental health and substance misuse. The service had links with the local criminal justice system to support clients who were leaving prison. Staff supported clients with no fixed abode and worked closely with the local authority to support homelessness.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

The service received 7 formal complaints in the period April 2021 to September 2022. These included complaints about treatment and care, staff and confidentiality. Six of these complaints were upheld, or partially upheld, by the service following investigation.

Clients knew how to complain or raise concerns. Clients were informed about how to make a complaint when they started treatment at the service. Clients said they knew how to raise a complaint or speak informally to staff if needed. One client reported they had made a complaint before and staff dealt with it promptly. They felt listened to by staff throughout the process.

The service had a complaints policy all staff members were informed about during their induction. It included an appeals process. Formal complaints were overseen at provider level. Managers investigated complaints and identified themes. Clients usually received the outcome letter within 28 days of making the complaint unless there were unforeseen delays. There was one occasion where the service required an additional time to complete their investigation and feedback to the client.

Managers and staff discussed complaints in supervision, at monthly team meetings and at senior management meetings.

Community-based substance misuse services

Are Community-based substance misuse services well-led?

Good 

We rated well-led as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for clients and staff.

Leaders could clearly explain their roles and demonstrated a sound understanding of the services they managed. Staff spoke positively about clients' recovery and how they supported them to achieve their goals.

Leaders were visible in the service and approachable for clients and staff. The registered manager and area service manager worked on site and were in close contact with staff throughout the day. The clinical lead was visible at the service and worked closely with staff to provide better outcomes for clients.

Vision and strategy

Staff knew and understood the service's vision and values and how they (were) applied to the work of their team.

Staff knew and demonstrated the service's vision and values and how they applied to the work of their team. The provider wanted to transform lives and co-produce this with the people they help. Staff emphasised the importance of supporting people to reduce their alcohol and/or drug intake and empowering their clients to make positive life changes.

Culture

Staff felt respected, supported and valued. They reported that the service promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

Staff reported that they felt positive about the work they did and supporting clients in their recovery. Staff felt able to raise concerns with management if they needed to. The service had a whistle blowing policy in place. The policy advised who staff should contact, both internally and externally, if they had concerns about poor practice.

Managers dealt with poor performance when needed. The manager was proactive in ensuring staff were appraised annually.

Staff worked well together as a team. Staff came together each day to discuss clients informally as well as at the monthly team meetings. Staff showed positive risk taking when discussing clients and advocated for client choice at every step of their treatment. Staff success was recognised through the provider's annual awards ceremony.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for development, for example through attending training. The provider offered extra training courses for staff to support with their development. However, at the time of the inspection staff did not report attending specialist training that would support their career development such as courses in leadership.

Community-based substance misuse services

Engagement

Staff, clients and carers had access to up-to-date information about the provider. Staff accessed information through emails and regular meetings. Clients and carers could use the organisations website for up-to-date information about what was going on with their services. Clients could give feedback on the service via client satisfaction surveys. The service had a tablet device in the waiting area for clients to provide swift feedback. Clients could also provide feedback about the service online.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.

The service had appropriate systems to evaluate the safety and effectiveness of the service. The provider had a clear framework of what had to be discussed at team meetings to ensure essential information was shared amongst the staff. The service held monthly team meetings where staff discussed pertinent information such as staffing, client assessments and emerging risks. The managers and senior clinical staff from other services met every quarter for central governance meetings. The minutes of these meetings from August 2022 showed staff discussed staffing structures, finances and risk.

Staff had implemented recommendations from reviews incidents and safeguarding alerts. The quarterly governance meetings would discuss complaints and serious incidents where appropriate.

Staff completed audits to provide assurance on the performance of the service. Staff audited care plans, risk assessments and the environment. However, audits did not include whether GP summary letters were uploaded onto the system when they were received in a timely way.

Staff knew to submit notifications to external bodies as required, for example to social services.

Staff also knew to make notifications to the Care Quality Commission in accordance with regulations.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The service maintained a risk register. This included staff recruitment and retention, the management of controlled stationery and medicines, infection control, violent and aggressive behaviour to staff. This ensured staff could identify the risks and planned for them.

The service had plans in place of an emergency, such as adverse weather conditions or an IT fault.

The provider used information to plan for service delivery. The service had a 'live' quality improvement plan for 2022/23, outlining the steps the service needs to take to achieve their service level goals. Goals included improving service accessibility and inclusion for underrepresented groups. Actions included enhancing and improving women's groups, staff training to develop LGBTQ+ and embedding the new ethnic minority outreach role.

Information management

Staff collected analysed data about outcomes and performance.

Community-based substance misuse services

The service used systems to collect data about performance. Managers had access to dashboards of client information, including overdue medical reviews and treatment schedules. Managers also had oversight of annual appraisal rates and mandatory training rates for staff.

Staff had access to equipment and information technology to support clients. Staff used an electronic record system to record client information.

The service manager and deputy service manager had access to information to support them in their managerial role. For example, HR records, supervision records and staff training data.