

WDP Redbridge

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Good



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

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

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

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

Summary of findings

Overall summary

We rated Westminster Drug Project Redbridge as **good** because:

- The service provided safe care. The premises where clients were seen were safe and clean. The number of clients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each client the time they needed. Staff followed good practice with respect to safeguarding.
- Staff provided a range of care and treatment interventions suitable for the client group and consistent with national guidance about best practice. They ensured that clients had good access to physical healthcare and supported clients to live healthier lives. The service user outcomes in relation to clients successfully completing treatment was above the national benchmark for all three pathways (alcohol, non-opiate and opiate).
- Staff treated clients with compassion and kindness, and understood the individual needs of clients. Clients were involved in the service in a number of ways. They could contribute feedback, attend service user forum meetings and make suggestions for service improvement. Staff welcomed their families and offered support to them, when appropriate.
- The service was easy to access. Staff planned and managed discharge well and had alternative pathways for people whose needs it could not meet.
- The service was well led, and the governance processes ensured that its procedures ran smoothly. Leaders had the skills, knowledge and experience to perform their roles, and staff felt respected, supported and valued.

However:

- Staff did not always comprehensively assess the risks to clients and did not always complete and review risk management plans to demonstrate mitigation of identified risks. Although staff demonstrated that they knew their clients well, and attended daily morning meetings where risks were discussed, this presented a risk because important information may get missed.
- Records were not always easily available to all staff providing care. Key documents relating to clients' care and treatment were not clearly labelled, so it was difficult finding certain records. This posed a risk to new staff or agency staff members who may struggle to find key documents when working with clients. Staff also told us that it was time consuming uploading documentation to the electronic system.
- Clients' care plans were often generic. Whilst they addressed clients' needs, they were not personalised or holistic.
- The service had not ensured that staff received all planned supervision in recent months, although staff told us that they felt supported and received supervision.
- When a client was assessed as having a mental health need, staff did not always liaise with the clients' mental health team. This meant that staff did not always obtain essential information on the client's mental health history, which would be useful to inform planning of care and treatment.

Summary of findings

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Good 

WDP Redbridge

Services we looked at

Substance misuse services;

Summary of this inspection

Background to WDP Redbridge

WDP Redbridge is an integrated community-based drug and alcohol recovery and detoxification service provided by Westminster Drug Project. WDP Redbridge took over the contract to provide all drug and alcohol services to the borough of Redbridge in April 2018. The adult service is free and open to Redbridge residents aged 18 or over, as well as their families and carers.

The service provides a range of treatments, which include prescribing and community-based detoxification, alcohol treatment programmes, one-to-one support, needle exchange, group work and counselling. Medicines were not held at this service. They were dispensed by several different pharmacies. Dispensing was pre-arranged with them all.”

The service was open on all week days, and one evening until 7.30pm.

There was a registered manager at the service at the time of the inspection.

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

This is the first inspection of WDP Redbridge since it registered with CQC in March 2018.

Our inspection team

The team that inspected the service comprised of two CQC inspectors, one CQC assistant inspector and one specialist advisor.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location. We notified the service of the inspection 48 working hours prior to the visit in line with our methodology.

During the inspection visit, the inspection team:

- visited the clinic rooms, looked at the quality of the environment and observed how staff were caring for clients
- spoke with two clients who were using the service
- spoke with four peer mentors who had or were using the service
- spoke with the service manager and the operations manager
- spoke with the staff grade psychiatrist who was the clinical lead for the service, two recovery practitioners, a social worker, two team leaders, a nurse, and an administrator.

Summary of this inspection

- looked at five care and treatment records of clients
- observed one staff morning briefing.

What people who use the service say

We spoke with two clients who were using the service, and four peer mentors who either had used the service or were currently using the service. Clients gave overwhelmingly positive feedback about the service they received. They described the environment as clean, safe and welcoming. They told us that staff were caring, supportive and non-judgemental towards them.

Clients said they enjoy services offered to them, which included acupuncture, alcohol and drug groups and mindfulness. They told us that the capital card scheme,

which allowed them to accrue points by attending appointments, was a good initiative and that they enjoyed spending points on toiletries and on group service user meals in the community.

Clients told us that since WDP took over the contract to deliver all drug and alcohol services in Redbridge in April 2018, that the service had improved and the care and treatment they received felt more organised.

Clients said that staff welcomed their families and offered support to them, when appropriate.

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 rated safe as **requires improvement** because:

- Staff did not always keep detailed records of clients' care and treatment. On admission, staff identified client risks, but they did not always record how these affected each client or develop risk management plans to address them. They also did not always update plans following changes in the client's presentation. Although staff demonstrated that they knew their clients well, and all staff attended daily morning meetings where risks were discussed appropriately, this presented a risk because important information may get missed.
- Records were not always easily available to all staff providing care. The electronic care record system did not allow staff to easily access all essential information. Key documents relating to clients' care and treatment were not clearly labelled, so it was difficult finding certain records. This posed a risk to new staff or agency staff members who may struggle to find key documents when working with clients. Staff also told us that it was time consuming uploading documentation to the electronic system.

However:

- All premises where clients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough staff, who knew the clients and received basic training to keep them safe from avoidable harm. The number of clients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each client the time they needed.
- Staff understood how to protect clients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service had a good track record on safety. The service managed client safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave clients honest information and suitable support.

Requires improvement



Are services effective?

We rated effective as **good** because:

Good



Summary of this inspection

- Staff completed comprehensive assessments with clients on accessing the service. They worked with clients to develop care plans and updated them regularly. The majority of care plans were not personalised or holistic, but all reflected clients' assessed needs.
- Staff provided a range of care and treatment interventions suitable for the client group and consistent with national guidance about best practice. They ensured that clients had good access to physical healthcare and supported clients to live healthier lives.
- The service user outcomes in relation to clients successfully completing treatment was above the national benchmark for all three pathways (alcohol, non-opiate and opiate).
- The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Staff at the service received specific training in substance misuse to ensure they could safely deliver their role.
- Staff from different disciplines worked together as a team to benefit clients. The service had regular team meetings to ensure multidisciplinary input into clients care and treatment.
- Staff supported clients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2015 and knew what to do if a client's capacity to make decisions about their care might be impaired.

However:

- Clients' care plans were often generic. Whilst they addressed clients' needs, they were not personalised or holistic.
- The service had not ensured that staff received all planned supervision in recent months, although staff told us that they felt supported and received supervision.
- When a client was assessed as having a mental health need, staff did not always liaise with the clients' mental health team. This meant that staff did not obtain essential information on the client's mental health history, which would be useful to inform planning of care and treatment.

Are services caring?

We rated caring as **good** because:

- 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.

Good



Summary of this inspection

- Clients were involved in the service in a number of ways, including at the monthly service user forum, and encouraged to leave feedback on how the service could be improved. They ensured that clients had easy access to additional support.
- The service had trained four peer mentors to support clients on their recovery journey. This was a nationally recognised qualification. Peer mentors had experienced issues with drugs and/or alcohol use and have overcome their dependency. Peer mentors co-facilitated groups, such as pre-detox group. This helped promote confidence and recovery.
- Staff informed and involved families and carers appropriately.

Are services responsive?

We rated responsive as **good** because:

- The service was easy to access. Staff planned and managed discharge well. The service had alternative care pathways and referral systems for people whose needs it could not meet.
- The design, layout, and furnishings of treatment rooms supported clients' treatment, privacy and dignity.
- The service participated in a provider wide, evidence-based reward card scheme to encourage clients to engage with the service. This reward scheme was developed in consultation with clients.
- The service had a weekly activity and group programme, which included groups such as alcohol and pre-detox groups, and complementary therapies such as auricular acupuncture, mindfulness, yoga and meditation.
- The service met the needs of all clients, including those with a protected characteristic or with communication support needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Good



Are services well-led?

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

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the service they managed, and were visible in the service and approachable for clients and staff.
- Staff knew and understood the organisation's vision and values and how they were applied in the work of their team.

Good



Summary of this inspection

- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work. They felt able to raise concerns without fear of retribution.
- Staff recorded incidents, complaints and compliments on the service's reporting system, which worked well.
- Staff collected and analysed data about outcomes and performance.

However:

- Although our findings from the other key questions demonstrated that governance processes generally operated effectively at service level. The service did not assure themselves that staff completed comprehensive risk assessments and risk management plans for clients or that clients' electronic care records were stored in an easily accessible manner.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff had completed training on the Mental Capacity Act, which included training on capacity and consent.

Staff understood mental capacity and were aware of how substance misuse could affect a client's capacity to






consent. Staff worked under the principle that they assumed the client had capacity to consent. When they doubted the client had the capacity to consent, they would complete a full assessment.

Overview of ratings

Our ratings for this location are:

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

Community-based substance misuse services

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

Are community-based substance misuse services safe?

Requires improvement 

Safe and clean environment

Safety of the facility layout

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

Staff carried personal panic alarms, and there were staff on site to respond to alarms. Staff tested the panic alarms monthly to ensure they worked. The service assigned two registered nurses each shift as first responders to attend to an emergency on-site.

Access to most areas in the building was secured. However, access to the toilets from the waiting room was not secured and the corridor between these two areas was not routinely observed by staff. This posed as a blind spot. This was raised with managers during the inspection, who told us that CCTV cameras had been installed, which covered the corridor between the toilets and waiting area.

Staff conducted a monthly health and safety audit to assess the safety of the building. The service assigned two fire wardens for each shift, which was discussed in every morning meeting so that staff were aware. We saw that a fire drill had taken place three months prior to our inspection, and all staff and clients had been evacuated safely. However, some staff had gone to the shops rather than gathering at the assembly point. This was addressed in the staff business meeting.

Maintenance, cleanliness and infection control

The areas clients had access to were visibly clean, comfortable and well-maintained. The service sub-contracted a cleaning company to clean the environment.

Staff adhered to infection control principles, including hand washing and wore appropriate personal protective equipment such as disposable gloves. Staff disposed of clinical waste appropriately.

The service had two clinic rooms, which were visibly clean and clutter free. One clinic room stored some medicines, which were all within their expiry dates. The room and fridge temperatures were checked regularly. This clinic room stored oxygen, however, there was no external precautionary signage to indicate oxygen storage. This was highlighted to senior managers during the inspection, who told us after the inspection that an oxygen sign had been placed on the clinic room door.

The second clinic room was used to undertake physical examinations. It contained equipment including an examination couch, scales and height measuring equipment. The equipment used was calibrated and visibly clean. However, there was no cleaning log to demonstrate the equipment was cleaned regularly.

Safe staffing

Staffing levels and mix

There were enough staff to meet the needs of clients accessing WDP Redbridge and the service could manage any unforeseen shortages in staff. WDP staff received

Community-based substance misuse services

relevant training to keep clients safe from avoidable harm. For example, in safeguarding and assessing risk. The service had a morning meeting to discuss staffing and cover arrangements.

The staffing establishment was one full-time service manager, one staff grade psychiatrist who was the clinical lead for the service, five registered nurses (including a non-medical prescriber), a nurse team leader (who was awaiting a start date at the time of inspection), three team leaders, one full-time social worker, 17 recovery practitioners (three of which were being recruited to at the time of the inspection), one community substance misuse trainer, one building recovery in communities practitioner, two and a half administrator posts, one data and performance lead, and two apprentice posts.

There were low levels of staff vacancies. At the time of inspection, there were three recovery practitioner vacancies, with one covered by an agency staff member. The service was interviewing for these posts the week following our inspection. The nurse leader role was vacant and was covered by an agency staff member. This post had been recruited into and the successful candidate was awaiting recruitment checks.

In the 12 months prior to the inspection, the staff sickness rate was 7%. At the time of the inspection, there was one staff member on long-term sickness, which was unrelated to work. In the last 12 months prior to the inspection, there had been six staff leavers. Reasons given for staff leaving included staff promotions, and a change in service provider.

The service had arrangements in place for annual leave and sickness absence. For example, staff covered each other during periods of absence. The service had a designated duty manager and duty worker assigned to each shift. They ensured cover arrangement were made for staff in their absence.

At the time of the inspection, the service had 407 clients accessing care and treatment. This was an average caseload of 29 clients per recovery practitioner. Staff reported that this was manageable. Recovery practitioners were responsible for booking appointments for clients, being involved in assessments, maintaining regular contact with them, and ensuring client records were kept up-to-date. Managers reviewed caseloads with recovery practitioners during supervision.

All medical reviews and prescribing were completed by the psychiatrist and non-medical prescriber. The service also had one non-medical prescriber who was also responsible for re-issuing prescriptions and administering medicines if needed. The staff grade psychiatrist and registered nurses were involved in clinical decisions. Out of hours, clients were advised to attend the local emergency department or dial 999 in the event of an emergency.

Mandatory training

Staff had received and were up to date with most of the mandatory training. Overall, staff in this service had undertaken 90% of the mandatory training. This included safeguarding children and adults, health and safety, Mental Capacity Act, first aid, and equality and diversity.

The service embedded personal safety protocols for staff to follow. Staff followed lone working protocols to ensure their safety on home visits. Staff used mobile phones when they visited client's homes and always went in pairs to reduce the risk. Staff discussed which staff were going on home visits in every morning meeting so that staff were aware of the time of visit and location.

Assessing and managing risk to patients and staff

Assessment of client risk

Staff did not always complete and update records of assessments and risk management plans. In clients' care records, staff did not always adequately describe identified risks for clients, develop robust risk management plans, or update these when risk had changed. Although staff knew their clients well and attended daily morning meetings and weekly clinical multidisciplinary meetings where risks were appropriately discussed, this presented a risk because important information may get missed.

During the inspection, we reviewed five risk assessments of clients. Although each client had a risk assessment on admission, two out of five did not record the fully context of risks identified.

For example, for one client, staff had identified risks of physical health issues and current contact with children. However, there was no further information on how these risks presented for the client. Staff did not always develop risk management plans to address identified risks. Three out of five risk assessments did not have risk management plans that considered all identified risks. For example, for two clients, staff had identified mental health concerns.

Community-based substance misuse services

However, the risk management plan did not demonstrate how the risk was being managed. This was raised with managers during our inspection, who told us they planned to liaise with mental health services regarding these clients.

Staff did not always review each risk assessment on a regular basis and update clients' risks assessments following a new risk incident, as appropriate. For one client, staff had identified a new domestic violence risk but had not updated the risk assessment. Staff had managed the risk, however, with evidence of a multi-agency risk assessment conference referral. Following the inspection, the service told us the risk assessment had been completed, but had not formally been updated on the electronic record system. The failure to update the assessments fully presented a risk because some members of staff may not be aware of the change in risk.

These concerns were raised with managers who told us that risk management training for staff had been brought forward to improve staff's understanding of risk assessment and management.

Staff undertook regular assessments of clients' physical health and referred them to their GP if they identified signs and deterioration in their health. From the five care records we reviewed, we found evidence that staff had requested and obtained physical health summaries from clients' GPs.

Clients were asked if they drove vehicles and were provided with information on action they needed to take. This followed best practice guidance (Assessing fitness to drive – guidance for medical professionals, DVLA, 2019).

Management of client risk

Staff educated clients about the risks of continued substance misuse and worked with them on harm minimisation to themselves and others. Clients were, for example, offered use of a needle exchange service, and distributed naloxone, a medicine for use in the event of overdose, with training on its use.

Clients had plans in place in the event of their unexpected exit from treatment. This included consent given by clients for home visits. Staff had a system in place to alert them if a client was not seen for 28 days or more, and they would attempt to contact clients in accordance with their previously agreed choices. For planned end of treatment, staff provided information to each client's GP, and where relevant to next of kin prior to discharge.

Staff saw clients on site or conducted home visits when necessary. Where there were concerns about clients' welfare that needed a home visit or changes in risk, this was discussed in team meetings prior to home visits being conducted as a team.

Safeguarding

Staff understood how to protect clients from abuse and the service worked well with other agencies to do so. Staff had access to the social worker employed by the service, who was the safeguarding lead. This meant that staff had a person they could go to for advice and guidance if they had a concern about a client's safety.

Staff could give examples of how to protect clients and others from abuse and neglect. This included clients with alcohol and drug issues who lived with young children and exploitation associated with substance misuse.

Staff had training on how to recognise and report abuse, and they knew how to apply it. Staff received training in level three safeguarding for children and adults. The social worker and staff grade psychiatrist were trained in safeguarding level five. Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies. Staff told us they referred any safeguarding concerns to the local authority's safeguarding team where the person lived. We saw evidence of staff referring a client to the multi-agency risk assessment conference (MARAC) when domestic abuse had been identified.

Staff were able to raise safeguarding concerns at daily morning meetings. The safeguarding lead attended external meetings, for example, the adults safeguarding policy and practice group, and the link worker meeting for children safeguarding at a local NHS trust.

The service delivered training titled 'understanding drug use and the impact on safeguarding children' to social workers and other professionals twice a year via the local children's safeguarding board.

Staff access to essential information

Staff used an electronic client record system. All assessments completed on paper were uploaded onto the electronic system for staff to access. However, the electronic system did not ensure easy access to essential information. During the inspection, we struggled to locate certain parts of clients' records. For example, a risk

Community-based substance misuse services

management plan had been uploaded to the wrong location, and some documents had been uploaded with names that did not clearly state what the document was. There was a risk that an agency staff member or a new member of staff joining the service would not be able to easily access important information to enable them to understand the client's care, treatment and risk management plans. This was highlighted to managers during the inspection, who told us that they were planning to introduce naming conventions to electronic records to ensure they were identifiable.

The electronic care record system had been commissioned by the local authority and differed from the system used by other WDP services. This meant it was hard for staff in the service to implement changes made to documentation by the wider organisation. Staff also told us that it was time consuming uploading paper documentation to the electronic system.

Medicines management

The service had policies, procedures and training related to medicines and medicines management including prescribing and detoxification. Medicines or controlled drugs were not held at this service. The staff grade psychiatrist and non-medical prescriber prescribed medicines. However, these were dispensed at a pre-arranged pharmacy.

The service stocked anaphylaxis kits and naloxone kits. These were all in date. The clinic room fridge contained Hepatitis B vaccine only. Registered nurses completed daily clinical checks, which included fridge and room temperature checks. Records demonstrated that the fridge was kept within recommended limits to ensure efficacy of medicines.

Track record on safety

In the last 12 months, there had been six serious incidents. These related to deaths of clients and a client with a physical health complication. The service completed robust investigations as required.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Staff had received training on how to report incidents using the electronic reporting system. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff shared learning from incidents in monthly integrated governance meetings. This was evidenced in January 2020's team meeting minutes, where staff discussed the outcome and key learning points from two client deaths.

In addition, WDP shared alerts from other services it provided, to ensure learning across the organisation. The service manager attended a regular meeting with other WDP service managers where key findings from serious incidents were discussed.

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

It was noted in January 2020's team meeting minutes, where learnings from a recent client death was discussed, that the client's risk management plan was not comprehensive of all risk factors associated with the client. These concerns were raised with managers who told us that risk management training for staff had been brought forward to improve staff understanding of risk assessment and management.

Are community-based substance misuse services effective?

(for example, treatment is effective)

Good 

Assessment of needs and planning of care

We reviewed five care and treatment records. Staff generally completed comprehensive assessments with clients on accessing the service. Assessments covered their history of drug and alcohol use, social needs, physical health and mental health needs, and family needs. Staff worked with clients to develop care plans, although these were not always personalised or holistic.

The recovery plan identified the client's key worker. Individual needs and recovery plans, including risk

Community-based substance misuse services

management plans were updated every 12 weeks, in line with the service's policy. However, staff did not always update these if circumstances changed within the 12 weeks.

Staff developed a plan for unexpected exit from treatment.

Staff met with clients face to face for assessment prior to prescribing medicines. This initial appointment for medication was with the staff grade psychiatrist.

Staff safely supported clients to reduce and stop their drug and alcohol use through the appropriate use of withdrawal symptoms audit tools and by following national guidance on detoxification.

Staff completed a treatment outcome profile (TOP) with clients to assess the degree of substance use. This was used for initial, review and exit stages. This could be used for substance misuse, injecting behaviour, crime and social functioning.

Client's care plans varied in their quality. Four clients' care plans were generic and not-person centred, although they did meet clients' needs. One care plan was detailed and comprehensive. For example, the client and staff member co-produced a personalised risk management plan in the event they disengaged from the service.

Best practice in treatment and care

The service provided a range of care and treatment interventions suitable for the client group. This included medication, rehabilitation groups, activities and training.

Staff followed National Institute for Health and Care Excellence (NICE) guidance for substance misuse and Public Health England guidance when prescribing medicines. Staff prescribed medicines to clients and gave advice on medicines in line with current national guidance. The service had recently introduced a new medicine for the treatment of opioid dependence, which was a prolonged-release medicine. The medical director and organisation's chief pharmacist had oversight of this injectable medicine.

The service was not commissioned to provide a psychologist, so clients did not have access to psychological treatment. However, the service had four volunteer counsellors who provided counselling support to clients.

The service routinely offered blood-borne virus (BBV) testing. Staff would re-offer the testing at a subsequent appointment if the client refused. Staff encouraged clients through a reward card scheme to attend for vaccinations. Points earned on the reward card scheme could be spent on local community services.

Staff supported clients to live healthier lives. For example, staff had been trained in smoking cessation and referred clients to a local smoking cessation service.

The registered nurses completed appropriate health and wellbeing checks on clients. This included checks of the pulse, temperature, blood pressure, blood tests and electrocardiograms. This included regular urine drugs screenings on clients as needed. Staff requested a summary of clients' medical history from their GP.

All clients were offered take-home naloxone, a medicine for reversing the effects of an overdose, which was in line with best practice.

Clients' individual meetings with staff were based on motivational interviewing, an evidence-based model to support behaviour change.

Monitoring and comparing treatment outcomes

The service reported treatment outcome profiles to the National Drug Treatment Monitoring System. They also had 28-day reports to review feedback on any outstanding TOPs forms.

Staff participated in clinical audits to help provide assurance on the quality of care and treatment delivered. This included audits of prescriptions, infection control and clinic room item stocks. The organisation had recently carried out a safeguarding audit to check that the necessary steps had been taken to safeguard the welfare of clients where needed.

The outcomes concerned clients completing treatment in a rolling 12-month period. For non-opiate clients, outcomes were in the top 25% of services (48% completion) and above the national benchmark. For opiate clients the service was in the top 25% of services (9% completion) and above the national benchmark. For clients having alcohol treatment, the service was in the top 25% of services (47% completion) and above the national benchmark.

Skilled staff to deliver care

Community-based substance misuse services

Staff were experienced and qualified. The clinical team included a full-time staff grade psychiatrist, five registered nurses (which included a non-medical prescriber), and a social worker. There were also recovery practitioners and team leaders for each pathway.

Staff at the service received specific training in substance misuse to ensure they could safely deliver their role. This included, safer injecting, needle exchange, group facilitation, motivational interviewing and solution-focussed brief therapy. Recovery practitioners completed a recognised competency framework for working in the health and justice sector.

The service had a community substance misuse trainer who delivered training to the community and stakeholders. For example, they delivered basic drug awareness to families and carers.

The service provided new staff with a local induction. The local induction included orientation to the service and reading the provider's policies and procedures. The induction included access to a resource centre where staff could complete additional online training and developmental goals for the year.

The percentage of staff that had an appraisal in the last 12 months was 89%.

Staff had not always received supervision in line with the service's policy, which outlined that staff should receive formal supervision every four to six weeks.

For example, in November 2019, records showed that 63% of staff received supervision, and in December 2019, 35% of staff received supervision. Managers told us that this was due to staff sickness. In January 2020, supervision rates had improved to 81%. However, staff told us that they felt well-supported and that they had received regular supervision.

The staff grade psychiatrist received an annual appraisal and regular supervision from the organisation's medical director.

Staff received training in meeting the needs of clients from diverse communities. This was covered as part of the equality and diversity training, which all staff attended. The service recently appointed a Black, Asian and minority ethnic (BAME) lead.

There were processes in place for managers to deal with poor performance promptly and effectively. For example, the team managers identified staff that were not performing well and placed them under performance management, with identified goals for improvements that needed to be made.

The service recruited four volunteer counsellors. They were managed by the organisation's counselling lead, who oversaw their placement and provided them with regular supervision.

Multi-disciplinary and inter-agency team work

Staff from different disciplines worked together as a team to benefit clients. The service ensured that staff from a range of disciplines, including the medical doctor, registered nurses, social worker and recovery practitioners, contributed to clients' comprehensive assessments. Where appropriate, they also sought external professional input, such as, from the client's GP, children and family services, and social workers. However, when a client was assessed as having a mental health need, staff did not always liaise with the clients' mental health team. This meant that staff did not obtain essential information on the client's mental health history, which would be useful to inform planning of care and treatment.

The service had regular team meetings. Staff met in daily morning meetings to discuss cases of concern, staffing, and any service updates. Staff shared pertinent information at these meetings including incidents and new safeguarding referrals. Staff attended monthly business meetings where topics such as performance and training were discussed. Staff also attended monthly integrated governance meetings where incidents and safeguardings were reviewed.

Staff attended weekly clinical multidisciplinary meetings either for the alcohol pathway or drug pathway. These meetings were chaired by the service's psychiatrist and staff discussed new presentations, discharges and disengaging clients.

The service discharged people when specialist treatment was no longer necessary. The service worked closely with relevant supporting services, such as GPs, to ensure relevant information was transferred.

Community-based substance misuse services

Staff recognised the importance of referring clients to other supporting services in the community, where appropriate. For example, accessing local sexual health support.

Good practice in applying the MCA

The service had a policy on the Mental Capacity Act (MCA). This meant that if staff required guidance on the MCA they had an internal document to refer to which, was relevant to their service.

Seventy-nine percent of staff had completed training on the MCA, which included training on capacity and consent.

Staff understood mental capacity and were aware of how substance misuse could affect a client's capacity to consent. Staff worked under the principle that they assumed the client had capacity to consent. When they doubted the client had the capacity to consent, they would complete a full assessment. Staff we interviewed were able to demonstrate their understanding of mental capacity by giving examples from their practice.

Are community-based substance misuse services caring?

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.

Staff attitudes and behaviours when interacting with clients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it.

Staff supported clients to understand and manage their care, treatment or condition.

Staff directed clients to other services when appropriate, and, if required, supported them to access those services. There was information available in the corridors of the service. These services included legal advice centres, and a support service that provided support for people that identified as lesbian, gay, bisexual, transgender, and queer.

We spoke to two clients and four peer mentors who had either used or were using the service. They all spoke very highly of the staff in the service. Clients said staff treated them well and behaved appropriately towards them. They told us that staff were caring, supportive and non-judgemental towards them.

Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. For example, staff took into account clients' needs in regard to religion and past abuse, and were able to assign gender-specific recovery practitioners, where relevant.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour attitudes towards clients without fear of the consequences.

Staff maintained the confidentiality of information about clients.

The service had recently introduced a boxing class called Gloves. This was conceptualised around a battle with drugs. Staff completed a medical screen and risk assessment prior to the first session, and staff completed a pre and post-boxing assessment regarding mood and thoughts. The boxing class had been popular with clients at the service, and there were plans to expand it across the organisation.

Involvement in care

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

Staff communicated with clients, so they understood their care and treatment. Staff offered clients information leaflets about the service.

Staff held regular appointments with clients to review their care and treatment plans, and staff gave information leaflets about their treatment for dependence on alcohol or an opioid based substance. One record we reviewed showed that a risk management plan had been discussed and signed by the client.

The service held monthly service user forums. Clients told us the service acted on feedback gathered in the forums that helped improve the service. The minutes from the service user forums were displayed in the waiting area for clients who were unable to attend.

Community-based substance misuse services

The service had a 'you say, we did' notice board in the waiting area. This was an opportunity for clients to give feedback on the service, and for staff to demonstrate how they have made changes. For example, clients wanted access to the timetable of activities and groups. At the time of the inspection, this was available via reception staff as they were making amendments to the timetable. This would then be displayed on a notice board.

The service had trained four peer mentors to support clients on their recovery journey. This was a nationally recognised qualification. Peer mentors were those who have had previous issues with drugs and/or alcohol use and have overcome their dependency. Peer mentors co-facilitated groups, such as pre-detox group. This helped promote confidence and recovery.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff involved family members in the care and treatment of clients when appropriate. Clients were encouraged to invite family members or a friend to attend their appointments with them and discuss their progress if they wanted to. Families were also involved when there had been a serious incident.

The social worker offered families and carers one-to-one support, where required. The service had recently started a carers support group, which ran four sessions over four weeks. Recovery practitioners delivered topics such as addiction, treatment options and what recovery looks like.

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

Good 

Access and discharge

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 robust alternative care pathways and referral systems in place for people whose needs could not

be met by the service. For example, clients who required extra support were sometimes referred to in-patient detox or residential rehabilitation. Clients who were under the age of 18 were often referred to the borough's young people's substance misuse service. There was a transition agreement in place between adult and young people's substance misuse services to ensure a smooth transfer from young people into adult services.

The service received referrals from GP surgeries, community mental health teams, social workers, homelessness centre and self-referrals.

Clients were assessed for treatment. Treatment commenced as soon as necessary medical checks had been performed.

Waiting times for non-urgent referrals to assessment was three to five working days. The duty worker screened referrals and contacted clients by phone or letter. The week prior to our inspection, three clients had self-referred and all had appointments the following day.

The service was able to see urgent referrals quickly. The duty worker had designated time slots during the day to see urgent referrals or clients who turned up to the clinic without an appointment.

There was a clear pathway for new clients taken on by the service, with the goal of achieving an appropriate transfer to other services such as a GP surgery, local community mental health teams, or another support network identified during their care.

The service had processes in place for when clients arrived late or failed to attend their appointments. Staff completed visited client's homes if failed appointments persisted. They wrote letters to clients to invite them to engage with the service and delivered these to client's home addresses.

Discharge and transfers of care

Staff planned for clients' discharge including liaising with the clients' GPs. Clients' treatment and discharge were discussed in team meetings. When a client was discharged the service sent a letter to their GP or current community mental health team confirming the outcome and whether any follow up was required.

Community-based substance misuse services

Staff supported clients during referrals and transfers between services. For example, staff handed over to professionals that they had referred clients to, with an update on their discharge.

The facilities promote recovery, comfort, dignity and confidentiality

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

The service had enough rooms for clients to meet with their recovery practitioner on the premises. The rooms were adequately sound proofed to maintain privacy. The reception space was spacious, bright and welcoming.

The service participated in a provider wide, evidence-based reward card scheme to encourage clients to engage with the service. This reward scheme was developed in consultation with clients. Updates of the scheme were available on their website and on twitter for clients and families.

The service had a weekly activity and group programme, which included groups such as alcohol and pre-detox groups, and complementary therapies such as auricular acupuncture, mindfulness, yoga and meditation.

Clients' engagement with the wider community

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

Staff encouraged clients to access the local community and social activities. There were some leaflets in the service about the types of services, which clients could access if they wished, as well as useful information on a range of topics.

When appropriate, staff ensured that patients had access to education and work opportunities. The service had a full-time building recovery in communities practitioner, who supported clients' reintegration opportunities in the community.

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.

Staff demonstrated an understanding of the potential issues facing vulnerable groups. For example, lesbian, gay,

bisexual, trans, and queer (LGBT+) clients, Black, Asian and minority ethnic clients, and people experiencing domestic abuse. The service had completed a LGBT+ toolkit to review how the needs of these clients could be met and improve service provision. Staff demonstrated good knowledge of supporting and understanding those who may be victims of domestic violence. The service also had a specialist recovery worker role as a Black, Asian, minority and ethnic lead.

Staff arranged interpreter services for clients as necessary for face to face and telephone appointments.

Clients said that staff rarely cancelled appointments. Staff met clients on the premises, or if there were concerns about a client's welfare joint home visits were considered. If clients failed to attend an appointment staff made every effort to contact them either by telephone, text messages or by contacting their next of kin and in some cases the client's GP.

The building was accessible for clients who lived with a physical disability.

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 the wider service.

The service had received ten formal complaints in the 12 months prior to inspection. Four were upheld by the service following investigation. These were related to waiting time for appointments and recovery practitioner changes. We reviewed four complaints and found the responses to be appropriate, with evidence of meeting with the client where appropriate.

Complaint investigations and outcomes were discussed at monthly integrated governance team meetings to ensure learning.

The service received 12 compliments between November 2019 and February 2020. Comments from clients included how group sessions had helped them with their rehabilitation and recovery.

Clients knew how to complain or raise concerns if they needed to. The clients we spoke with told us they knew

Community-based substance misuse services

how to make a complaint. The service also had complaints and compliment leaflets accessible to clients, that advised them how to make a complaint. These were displayed in the waiting area.

Staff knew how to handle complaints appropriately. Staff dealt with informal complaints immediately if a client or their representative approached them. If necessary, staff escalated the complaint to the team managers or service manager.

Are community-based substance misuse services well-led?

Good 

Leadership

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

The service's psychiatrist was experienced in mental health and substance misuse. They provided local clinical leadership to the service and was supported by the medical director who provided overall clinical leadership.

Leaders had a good understanding of the service they managed. They could clearly explain how the teams were working to provide high quality care.

The organisation had a clear definition of recovery and this was shared by and understood by all staff.

Leaders were visible in the service and approachable for clients and staff. Staff were very positive about the leaders in the service. Staff described the service manager as approachable and supportive in their day to day work activities. The organisation's medical director had attended some of the service's team meetings.

Vision and strategy

Staff knew and understood the organisation's vision and values and how they were applied in the work of their team. The organisation had four values: entrepreneurial, in partnership, community focused and strong belief in service users. The mission was to provide a wide range of treatment and recovery provisions to service users and their families in partnership with local providers.

All staff had a clearly defined job description.

Staff had opportunities to contribute to discussions about the vision and strategy of the service through team away days and at team meetings. The last away day was held in November 2019.

Culture

Staff felt respected, supported and valued by their colleagues and managers. They reported that the provider promoted equality and diversity in its day-to-day work. They felt able to raise concerns without fear of retribution.

Staff were overwhelmingly positive about working at WDP Redbridge. They described the morale in the team as very good and staff supported each other.

During the inspection, managers highlighted to us that some staff were unsure of the organisation's future direction, as the service was two years into a three-year contract. Managers said there was a possibility that it could be extended to a five-year contract, and kept staff up-to-date on the matter through regular team meetings.

Staff felt able to raise concerns without fear of retribution.

Staff had access to support for their own physical and emotional health needs through an occupational health service.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for development. For example voluntary staff could become substantive members of the team.

Teams worked well together and where there were difficulties managers dealt with them appropriately.

Governance

Our findings from the other key questions demonstrated that governance processes generally operated effectively at service level.

There were systems and procedures to ensure that the service was safe and clean, that there were enough staff, that staff were trained, that clients were assessed and treated well, and complaints were reported, investigated and learnt from.

Community-based substance misuse services

The service's governance policies, procedures and protocols were regularly reviewed and improved. The service was in the process of putting together a standard operating policy for the service.

The service 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 pertinent information was discussed.

Staff undertook local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed.

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.

Although staff knew their clients well and discussed risks to clients at daily morning meetings, the service did not assure themselves of the quality of the risk assessments and risk management plans for clients using the service.

Staff discussed recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. However, we found staff had not robustly implemented recommendations from a recent death. It was recommended that risk management plans should include all risk factors associated with the client. We found this not to always be the case in the care records we reviewed.

The service generally understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients. However, in two of the five care records we reviewed, staff did not always liaise with mental health teams when there had been an identified mental health risk/history or need.

Management of risk, issues and performance

There was a clear quality assurance management and performance framework in place. The service had to submit a quarterly key performance indicator report to commissioners. This included quality and outcomes for clients, general service activity and safeguarding, complaints and serious incidents.

Managers maintained and had access to the risk register at service level. Staff could escalate concerns and risks via managers when required. Staff concerns matched those on the risk register.

The service had plans for emergencies – for example, adverse weather conditions or IT outage. For example, there were three back up connection lines in the event of an IT outage.

The service monitored staff sickness and absence rates, alongside client completion rates.

Information management

Staff recorded incidents, complaints and compliments on the service's reporting system, which worked well.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well. However, the electronic patient system did not allow staff to upload documents in a timely manner. It was also difficult to locate certain client documents as they were often saved in different locations or not clearly labelled.

The service manager said they had access to information to support them in their management role. For example, supervision records, training data, sickness records, health and safety audit and annual leave requests.

The service ensured confidentiality agreements were clearly explained including in relation to the sharing of information and data.

Staff made notifications to external bodies where required, including CQC.

Engagement

Staff, clients and carers had access to information about the provider. Staff and clients could access the organisation's website and twitter page for information about services.

Clients could give feedback in a variety of ways. The waiting room had information on how to make a complaint / compliment, a box for clients to provide feedback. They could also attend the monthly service user forum to provide feedback.

Community-based substance misuse services

Staff told us that since WDP Redbridge took over the contract to deliver all alcohol and drug services in Redbridge, there was more emphasis on what the clients wanted.

Staff were able to meet with members of the service's leadership team and give feedback, which led to change. One staff member told us that they suggested introducing a boxing class as part of recovery for clients with drug issues. This was agreed to and supported by the WDP chief executive.

Service leaders engaged with external stakeholders, such as commissioners.

Learning, continuous improvement and innovation

Staff collected and analysed data about outcomes and performance. The service submitted a quarterly report to commissioners on the quality and safety of the service and used the data to improve services.

The service's psychiatrist was trained in eye movement desensitisation movement therapy and was starting a pilot study for clients with trauma.

Outstanding practice and areas for improvement

Outstanding practice

The service had recently introduced a boxing class called Gloves. This was conceptualised around a battle with drugs. Staff completed a medical screen and risk assessment prior to the first session, and staff completed

a pre and post boxing assessment regarding mood and thoughts. The boxing class had been popular with clients at the service, and there were plans to expand it across the organisation.

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure that staff create good risk management plans that robustly assess and manage risks to patients, and that all staff are trained in assessing and managing risk.

Action the provider **SHOULD** take to improve

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

- The provider should ensure all staff have regular supervision.
- The provider should ensure that all staff can easily access essential information on the electronic care record system, and ensure that key documents relating to clients' care and treatment are clearly labelled.
- The provider should ensure that staff liaise with a client's mental health team when a mental health need has been identified, to ensure effective planning of care and treatment.

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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Staff did not always comprehensively assess the risks to clients and did not always complete and review risk management plans to demonstrate mitigation of identified risks.</p> <p>This was breach of regulation 12 (1) (2) (a) (b)</p>

This section is primarily information for the provider

Enforcement actions

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.