Turning Point

Turning Point - City of London and Hackney Integrated Drug & Alcohol Service

Inspection report

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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	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

The service has not been inspected before, therefore the service has not been previously rated. We rated it as requires improvement because:

- The service did not have an effective governance system. Managers did not ensure that all necessary improvements had been made promptly when issues were identified. The service did not maintain an accurate log of when staff supervision had taken place. The outcomes of incidents, complaints and safeguarding cases were not discussed and recorded within individual team meetings. During our inspection, we identified several areas of practice that had been identified for improvement, but staff had not made the changes in their everyday practice. The provider was aware of the areas of practice that required improvement but had not taken quick enough action to address them.
- The service had not ensured that clients who were required to receive an electrocardiograph (ECG) had been offered one. An audit carried out in June 2021 identified that 11 clients who were prescribed over 100mls of methadone had not been offered an ECG within the last 12 months. At the time of our inspection, the service had still not ensured that the clients had been offered an ECG. The lack of urgency in ensuring clients received an ECG increased the risk of clients' suffering heart complications or failure as a result of their prescribed medication.
- Some client records lacked important information and highlighted gaps in care. We identified that there was an inconsistent approach to the recording of risk management plans and re-engagement plans. In one record, we found that the clients' GP had not been contacted since November 2020 despite the client undergoing a community alcohol detoxification. This increased the risk of the client not being supported or monitored by their GP.

However:

- Senior leaders knew what areas required improvement. Whilst we identified that the service should have responded more quickly to make some necessary improvements, the senior leaders had already identified most areas of improvement prior to our inspection. The staff had worked hard to ensure they maintained a service throughout the second lockdown of the Covid-19 pandemic.
- Staff encouraged clients to manage potential overdose risks as well as supporting them to live healthier lives. Staff had distributed naloxone kits to 68% of clients either via the pharmacy or the service directly. Naloxone is a medicine that reverses an opiate overdose. The provider had a target date to distribute to all clients by December 2021. Staff regularly offered clients dry blood spot testing (DBST) to identify those clients with a blood-borne viruses (BBV) such as hepatitis C. The service had trained 98% of staff in DBST.
- The service had an established involvement group for people who use services. The group were actively involved in improving the service. This included participating in staff interview panels.
- Clients were mainly positive about the service and felt the staff were caring. Clients understood that the service had been affected by the Covid-19 pandemic but did reflect that they missed the support from their peers in a face to face group setting. The service had continued to provide some of their groups virtually because of the risk of Covid-19.
- The service was building good working relationships with other care providers and community organisations. The service had recently been given additional funding under a new government project to tackle drug-related crime. The additional funding enabled the service to recruit more staff and employ more specialist roles such as a criminal justice family worker.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community-based substance misuse services	Requires Improvement 	See overall summary above.

Summary of findings

Contents

Summary of this inspection

Background to Turning Point - City of London and Hackney Integrated Drug & Alcohol Service

Turning Point - City of London and Hackney Integrated Drug & Alcohol Service provides advice, support and treatment to adults who misuse drugs and alcohol and live in the City of London and the borough of Hackney. The service has been operating for 11 months; prior to this, another provider had been delivering the service. The provider had experienced challenges in the implementation of the new service due to the second wave of the Covid-19 pandemic. Despite staff working remotely, the service continued to deliver care and treatment to clients. The service's main hub is based on Mare Street, London which is used to hold clinics and deliver the group programme.

The service was going through a period of transition and teams were being restructured to align with the service's delivery model, which was based around neighbourhoods. The service provided care and treatment to clients in the community where clients would usually visit, such as the GP, community centres and hostels. The service comprised of several teams including a criminal justice team, neighbourhood teams (North and South), rough sleeping team and an assessment team. In November 2021 the service planned to launch their new clinical pathways that would see clients being supported and treated by a dedicated team who have the right knowledge and skills to support a client and their needs. This meant that staff could access specialist training to support their role more effectively.

The service worked in partnership with Antidote, a drug and alcohol support service that is ran by people who identify as lesbian, gay, bisexual and transgender (LGBT), and MIND, which is an independent mental health charity. Both organisations provide specialist support to the staff and clients at the service and enables them to support hard to reach communities.

The service was registered to provide the following regulated activity: Treatment of disease, disorder or injury.

The service was commissioned by the London Borough of Hackney and City of London Corporation Public Health Team.

There was a registered manager in place for the service. At the time of our inspection, the registered manager was on leave.

The Care Quality Commission had not previously inspected this service.

How we carried out this inspection

We carried out a comprehensive inspection of this service to check it was safe, effective, caring, responsive to people's needs and well-led. We visited the service on 23 and 24 September as well as 6 October 2021. Our inspection team comprised of three CQC inspectors, an expert by experience and a specialist professional advisor who was a consultant in addiction psychiatry.

During this inspection we:

- spoke with five clients who had used the service
- spoke with 14 staff members employed by the service including nurses, doctors, recovery workers, team leaders, operations managers and administrators

Summary of this inspection

- reviewed electronic records detailing the care and treatment of 11 clients
- reviewed four prescription charts
- reviewed prescribing and the medicines prescription process
- looked at policies, procedures and other documents relating to the running 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:

The service had built a good working relationship with the Bart's Health local operational delivery network (ODN) who delivered treatment for blood borne viruses such as hepatitis C on the premises of the service. The service provided free clinical space to the ODN to enable them to treat clients who also accessed the service for their substance misuse. The service had trained 98% of their staff to carry out dry blood spot testing. This is a type of test that checks if a person has a blood borne virus such as hepatitis C.

Areas for improvement

Action the service MUST take to improve:

- The service must ensure that effective governance processes are in place that enables leaders to maintain oversight across the service and respond quickly to areas of improvement. **Good governance Regulation 17 2(a).**
- The service must ensure that client records are comprehensive in detail and that clients receive the required health checks including an ECG if they are prescribed over 100mls of methadone. **Safe care and treatment Regulation 12 (1)(2) a, b.**
- The provider must ensure that the Care Quality Commission is notified of all incidents requiring notification, without delay. **Notification of other incidents Regulation 18 18(1)(2)(e) (Registration) Regulations 2009.**

Action the service SHOULD take to improve:

- The service should ensure that it assesses the competency of staff to deliver clinical interventions, such as administering intramuscular medicines and vaccinations.
- The service should ensure that clinicians clearly document their clinical rationale for decision making in all cases, especially if a clinician deems that a recognised assessment tool is not required to support their clinical judgement.
- The service should ensure that voided prescription forms are discarded in accordance with NHS Counter Fraud Authority guidance.

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Community-based substance misuse services

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

Are Community-based substance misuse services safe?

Requires Improvement

Safe and clean environment

Most areas of the clinical premises where patients received care were safe, clean, well equipped and well maintained. Staff had carried out a recent environmental and fire risk assessment as well as an infection control audit. Pull cords were available within the service user toilet facilities and panic alarms were in all clinical areas and corridors. The service held a well-stocked emergency grab bag that included adrenaline in the event of a client having an allergic reaction (anaphylaxis) and naloxone in the event of a client overdosing using opiate substances.

Whilst the waiting area was fit for purpose, the area was being used for storage. For example, we found a large opened bag of water softener tablets stored behind a plant pot. This was not a safe storage space and we raised this to the provider to address.

Safe staffing

Whilst the service had several vacant posts, the provider ensured that they had controls in place to reduce the vacancies. The provider had 11 vacancies in total. There were four clinical vacancies, four recovery worker vacancies and one administrator vacancy. There were also two vacancies for specialist roles through partnerships with Mind in Hackney and London Friend. The service had active recruitment plans in place as well as using long-term agency staff. The provider recognised the high demand for nurse medical prescribers and the impact of this on the service. The leaders of the service planned to recruit two non-medical prescribers. Non-medical prescribers are health professionals who can prescribe specific medicines. These new members of staff would not necessarily be experienced in substance misuse, but the provider told us that this would be an opportunity to develop staff in-house and utilise the skills and competence of the clinical team to train them.

The service employed enough staff who were able to provide both clinical and medical support. The medical team was made up of one permanent consultant addiction psychiatrist and one doctor who was a locum. The service employed three permanent non-medical prescribers and two locum non-medical prescribers. The service also employed a hospital liaison nurse who worked four days per week as well as three wellbeing nurses, one of which was employed by the providers internal bank employment scheme. During core working hours, recovery workers could get support from a psychiatrist or non-medical prescriber quickly when they needed to.

The provider estimated staffing numbers by taking into consideration the average caseload sizes per recovery worker as well as the number of sessions a client would require across a 12-week period. The average caseload for a recovery worker was 60. Some clients were cared for alongside their GP, which is known as GP shared care. Clients having this type of care do not require as intensive support from substance misuse services.

At the time of our inspection we reviewed the records of five individual staff members. The records showed that the provider had ensured that staff had completed an induction and had carried out pre-employment checks including Disclosure and Barring Service (criminal records) check (DBS) and employment references.

Mandatory training

Most staff had completed and kept up to date with their mandatory training. At the time of our inspection the mandatory training compliance rate was 83% compliance. The provider told us that they aimed for 85% compliance and had a workforce plan in place to support staff. Managers monitored mandatory training and alerted staff when they needed to update their training. The mandatory training programme was comprehensive and met the needs of patients and staff. Training sessions included mental capacity awareness, autism awareness, basic life support and harm reduction.

The provider had not ensured that two clinical members of staff had received a Turning Point competency-based assessment to ensure they could safely administer intramuscular (IM) thiamine injections (Pabrinex) and other vaccinations. Two members of staff had not completed a competency-based assessment since the provider had taken over the service in October 2020. The assessment would be to ensure the staff were able to safely administer Pabrinex under Turning Point guidelines. Pabrinex is a vitamin supplement that is administered via an injection to clients that are at risk of neurological problems due to their alcohol dependence. We found that one member of staff had administered a Pabrinex injection on 28 September 2021 without being reassessed as competent. Whilst the clinical staff were qualified non-medical prescribers and were experienced in their field, the clinical team did not routinely administer Pabrinex injections. This increased the risk of the staff members not being up to date with the latest evidence-based guidance and could put clients at risk. We raised this to the provider at the time of our inspection. On 8 October 2021, the provider sent the Care Quality Commission (CQC) a completed and up-to-date competency assessment for both members of staff. Following the inspection, the provider told us that the nurse who had administered Pabrinex on 28 September 2021 was an experienced nurse working in substance misuse services for many years.

Assessing and managing risk to patients and staff

Clients received a comprehensive assessment when they first attended the service. The initial assessment covered potential risks including current and historic substance misuse, forensic history, caring responsibilities and physical health. Staff had ensured that clients who held a driving licence were informed that they should inform the Driver and Vehicle Licencing Agency (DVLA) of their substance misuse and treatment. This was in line with national guidance. Clients were discussed at a weekly MDT meeting and allocated to a keyworker depending on their risk and needs.

Staff had not ensured that they maintained comprehensive client records. We reviewed 11 client records and found that five of the records required improvement. For example, three records lacked detailed risk management plans despite the risk assessment highlighting that the clients were at risk of self-neglect and suicidal intent. In another record, staff had not recorded that they had contacted a client's GP when they started a community detox. The same client had not received any contact from the service since July 2021, due to a keyworker being away on long-term sick leave. The provider had not identified the lack of contact until we raised it. The lack of consistent record keeping and risk management increased the risk of clients not receiving the care and support they require which could put their safety at risk.

Clients were encouraged to manage potential risks including opiate overdose. Staff encouraged all clients who used illegal drugs to keep naloxone nearby. Naloxone is an emergency medicine used to reverse the effects of an opiate overdose. The service kept a stock of Naloxone and monitored the distribution rates. Since the service took over from the previous provider in October 2020, the provider had distributed kits to 68% of clients either via the pharmacy or the service directly. The provider had an action plan in place to ensure the outstanding number of clients were offered a naloxone kit. The provider had a target date of December 2021 to reach 100%.

Safeguarding

Staff understood how to protect clients from abuse and worked with other agencies to protect them. Eighty-nine percent of staff had completed safeguarding vulnerable adults and children level two training. The service had made 22 adult safeguarding referrals and three child safeguarding referrals in the last 11 months since the service opened. Staff had made a high number of phone calls to the Multi-agency Safeguarding Hub (MASH) consultation line. The service was developing links with the safeguarding partnerships boards and attended the Multi-agency Risk Assessment Conferences (MARAC) every fortnight. The safeguarding manager had agreed plans to co-locate with the Hackney MASH team, which would improve communication and build stronger relationships.

The service employed a variety of roles to support vulnerable clients, carers and their families. The service employed a safeguarding manager who also led the family, friends' and carers team. The team supported families and women who have children or who are pregnant. The service also employed a woman's worker and held a perinatal multi-disciplinary team meeting twice a month to discuss clients who were pregnant and clients with children under the age of one. Staff told us that the safeguarding manager was present at meetings and was supportive.

The provider recognised that the safeguarding systems and processes needed further development and had action plans in place to support the improvements. The service had developed three members of staff to become safeguarding leads and had recently implemented a more consistent approach to the safeguarding leads meeting. Although staff had opportunities to discuss safeguarding concerns at the MDT meetings, individual teams did not consistently discuss safeguarding at a team level. We reviewed a sample of team meeting minutes from February and July 2021 and found that safeguarding themes or risks had only been discussed in the Neighbourhood South team. The provider carried out an internal quality inspection in August 2021 and identified the same area for improvement. The areas for improvement were monitored at the clinical governance meeting. The lack of discussion at team level increased the risk of staff missing important safeguarding updates and an opportunity to reflect about safeguarding processes.

Medicines management

Whilst the service had a system in place to store and process prescriptions, the provider had not ensured that individual prescriptions that were no longer in use, also known as voided, were disposed of within a reasonable amount of time. At the time of our inspection, there was a backlog of voided prescriptions dating from May 2021 to September 2021. Best practice guidance states that prescriptions that are no longer in use should be securely destroyed (NHS Counter Fraud Authority, 2018). Although the voided prescription forms were being held in a secure place within the service, the provider had not followed best practice guidance to ensure that the prescriptions were destroyed as soon as possible once they were no longer required. Individual client records had been updated to reflect that the prescription form had been cancelled. The CQC returned to the service on 6 October 2021 and found that the provider had appropriately discarded the void prescriptions.

At the time of the inspection we found that the service did not have a spare master key available in the event that the key to the key cupboard was lost. This increased the risk of staff not being able to access important storage facilities within the service. Following the inspection, the provider told us that a spare master key was available and that this had been miscommunicated to the inspection team.

Requires Improvement

Community-based substance misuse services

The clinical administrative team and non-medical prescribers completed checks to minimise the risk of issuing an incorrect prescription to a client or pharmacist. We reviewed four prescription charts and eight client records. Although one prescription chart was illegible and the dosage amount was not clear, we found that the prescribing of medicines followed national guidance. We escalated the illegible prescription chart to the senior clinical administrator to address. Non-medical prescribers had set times to review and write prescriptions. The service ensured that clients who had complex histories were seen by a doctor.

When staff were unable to contact a client, they ensured that the client's prescription pick up was reverted to 'script in hand'. This meant that the client was required to visit the service to collect their script from a member of staff. This provided an opportunity for the service to engage with the client.

Track record on safety

The service reported no serious incidents since it started operating 11 months previously.

Reporting incidents and learning from when things go wrong

Whilst staff were confident in recognising and reporting incidents, we found that incidents were not routinely discussed at team level and some areas of learning had not yet been embedded into practice. We reviewed a sample of team meeting minutes from February and July 2021 and found that incidents had only been discussed in the Neighbourhood South team. We found that senior managers discussed incidents within their clinical governance meetings and at a dedicated meeting for death incidents. However, the individual team meeting records did not reflect that the learning had filtered down and practice had changed as a result.

The provider had identified from their own incident reviews that record keeping needed improvement. For example, the learning from a client death in May 2021 identified that a client's risk assessment and risk management plan was not detailed. We also found that the quality of risk management plans and re-engagement plans had not improved and were not consistently recorded in the clients' record. Managers did not ensure that learning from incidents was discussed at team level, which meant that staff were not aware of the improvements required and did not have a record to refer back to if needed.

Staff understood the term duty of candour. Providers of healthcare services must be open and honest with patients and other 'relevant persons' (people acting lawfully on behalf of patients) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Staff were able to provide examples of when they would offer support and apologise.

Are Community-based substance misuse services effective?

Requires Improvement

Assessment of needs and planning of care

Whilst staff ensured that most clients received a comprehensive assessment when they first attended the service or prior to treatment beginning, in two out of 11 records we reviewed staff had not screened clients using a recognised withdrawal tool. One client, who was alcohol dependent, had not been assessed using the Severity of Addiction Questionnaire (SADQ) or a similar tool. Another client had not been assessed using the Clinical Opiate Withdrawal Scale (COWS). This tool is used for clients who use heroin, or other opiate drugs. Both tools are recommended nationally by the National Institute for Health and Care Excellence (NICE) and the Department of Health and Social Care. At the time of the inspection, we raised our concerns to the provider. The provider told us that a telephone assessment had been

carried out with one of the clients to assess the severity of their withdrawals, however, the outcomes had not been formally recorded. The risk of staff not consistently using a tool to record the severity of a client's withdrawals meant that there was no formal record to refer back to that demonstrated how the member of staff came to their clinical judgement.

Staff developed detailed recovery care plans for most clients, but they did not always record client re-engagement care plans. These plans are referred to if a client disengages from the service. In two care records we found two good practice examples of where staff had positively reengaged the clients and had ensured that they were supervised taking their medication by a pharmacist. However, in three out of 11 records, staff had not recorded a re-engagement plan. Although the provider had re-engagement guidance in place for staff to refer to, this was not specific to the client.

The service had launched a dedicated assessment team to ensure that the quality of clients' assessments improved. At the time of our inspection, the team had recently formed and were responsible to ensure a consistent approach in the assessment of new client referrals.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Clients were prescribed medicines in accordance with national guidance, such as NICE. Clients who misused alcohol were prescribed thiamine, a vitamin in which people dependent on alcohol are at risk of being deficient. The service administered four intramuscular (IM) thiamine injections between July and September 2021. This is required when people are at risk of significant neurological problems. Staff ensured that they used a formal scoring tool to assess whether a client required oral thiamine or IM. The service was also introducing the prescribing of a medicine called Buvidal. Buvidal is used to treat opioid dependence. Prescribing protocols were in place for all of the medicines prescribed in the service.

Staff made sure patients had support for their physical health needs, either from their GP or community services. Clinicians ensured that when clients were first assessed in the service, they provided a urine sample to be tested for drugs. The test results were used to confirm whether the client was using illegal drugs. We found that staff requested clients to participate in a urine drug screen on a regular basis. Staff also ensured that clients were routinely breathalysed to confirm their alcohol consumption. This meant that clients who were prescribed medicines could be monitored accordingly. This followed best practice guidance (DH, 2007).

Staff supported patients to live healthier lives by supporting them to take part in regular screening programmes or giving advice. The service had established an on-site weekly dental clinic, which aimed to see clients who are harder to engage in the community. This included clients who are street homeless or those who have experienced barriers to accessing a dentist. The service had worked hard to improve their offer of dry blood spot testing (DBST) to identify those clients with a blood-borne viruses (BBV) such as hepatitis C. The service provided free clinic space to nurses of the local operational delivery network who deliver treatment to clients who test positive for BBV. The service closely monitored their offer of DBST and identified that in July 2021, 68 tests were performed. The service had trained 98% of their staff to carry out DBST.

The service had not ensured that clients who required an electrocardiograph (ECG) were offered a test in a timely way, despite identifying clients who were at greater risk. In June 2021, the service had carried out an audit to understand the number of clients who were prescribed over 80mls methadone and had not received an ECG. The audit identified that 11 clients were prescribed over 100mls of methadone and 44 clients were prescribed between 80-100mls of methadone and did not have an up to date ECG recorded. National guidance (DH, 2007) states that for clients prescribed over 100mls of methadone there is an increased risk of heart problems, therefore detecting any abnormalities is vital.

Although the service had provisional plans in place to offer all high-risk clients an ECG, at the time of our inspection the ECGs had not been completed. The inspection team escalated this to a senior leader. The provider responded promptly and contacted the CQC on 13 October 2021 to confirm that all 11 clients had received an up to date ECG. The lack of urgency in ensuring that clients prescribed over 100mls of methadone were offered an ECG increased the risk of clients suffering heart complications or failure as a result of their prescribed medication.

Staff took part in clinical audits. The service carried out clinical audits including infection prevention and control and clinical equipment audits. The provider carried out an internal quality inspection in September 2021, which identified several audits that were not routinely carried out. This included a prescription management audit and regular safeguarding case record audits. The service had ensured that a prescription management audit had been carried out in September 2021. The service had a wider safeguarding action plan in place that was being progressed by the safeguarding lead.

Skilled staff to deliver care

The teams included a range of disciplines required to meet the needs of patients under their care. The service employed psychiatrists, non-medical prescribers with a background in substance misuse, a psychologist and dual diagnosis workers. The provider had planned to recruit two non-medical prescribers to the service that did not have a background in substance misuse, due to the high demand for non-medical prescribers. The service planned to train and develop the new staff members using the provider's internal competency assessment frameworks.

The service model was being adapted to include treatment pathways that would be led by members of staff with specialist backgrounds. The model included an alcohol pathway that would be led by a nurse who had a specialist background in alcohol misuse and was also a non-medical prescriber.

Management supervision records did not accurately reflect supervision rates. At the time of our inspection, the provider shared a supervision audit for August 2021 that showed out of 69 staff recorded there were 13 new members of staff who were not recorded as having any supervision, three members of staff were recorded as having had no supervision since April 2021 and six members of staff were recorded as having had no supervision since May 2021. The provider expected staff to participate in management supervision once every eight to 12 weeks. Supervision frequency was not routinely logged which meant that the provider was unable to maintain oversight that supervision was taking place, therefore increased the risk that staff did not have an opportunity meet with their line manager to discuss their performance and wellbeing.

Following the inspection, the provider told us that at the time of the inspection they had sent the CQC an incomplete supervision audit. The provider shared with CQC a revised version of the August 2021 audit which demonstrated the outcomes of multiple supervision audits carried out by different members of staff. Whilst the additional information demonstrated an improvement in supervision completion rates, at the time of our inspection the supervision log was not accurately updated, and it was our inspection that had prompted the provider to revisit the completeness of the supervision audit available.

The non-medical prescribers received regular clinical supervision. The consistency of clinical supervision sessions had improved from April 2021. The clinical services manager who was an experienced non-medical prescriber provided supervision once a month. Staff were not always available because of annual leave, however, there were other opportunities for staff to receive clinical support. For example, the non-medical prescribers and medical team supported each other during monthly group supervision sessions and during the weekly clinical team meeting.

Requires Improvement

Community-based substance misuse services

The service had identified specialist training that would provide staff with the skills and tools to carry out their role effectively. The leaders of the service had created a training calendar, which included sessions on specialist trauma informed care and crisis survival skills. The service had planned for staff to complete a pregnancy and substance misuse development session in October 2021. Safeguarding development sessions were held regularly which included topics such as how to record safeguarding incidents and the processes to follow. Staff told us that the team psychologist provided a psychosocial intervention session every two weeks.

Multidisciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit clients. The teams came together every morning to hold a meeting to discuss clients, incidents and handover general information. We observed a morning meeting and found staff openly discussed their opinions and seek support for their colleagues and managers. The team held MDT meetings throughout the working week to ensure that colleagues with specialist backgrounds were able to provide support. For example, the service held a perinatal MDT meeting, a complex case meeting that incorporated safeguarding, and a meeting to discuss clients who were homeless.

The service had built links with external organisations and had employed members of staff to improve relationships with community services. The service had employed a pharmacy and GP shared care manager to improve links with GPs and community pharmacists. The service was in early conversations with local GPs to grow and improve GP shared care. The service had built a good working relationship with the local hepatitis C operational delivery network, who deliver treatment to clients with a blood borne virus. The service provided free clinic space to the nurses of the network to carry out treatment for BBV as well as offering clients a liver screen whilst they are in the clinic. The team included a hospital liaison worker who was based within the local acute hospital and attended the service's MDT meeting to provide support to staff and handover clients who may require an intervention.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions about their care for themselves. Staff understood the main principles of Mental Capacity Act. They could describe examples of clients being intoxicated and this being a reason to review their capacity to consent. The clinical team and consultant psychiatrist would conduct a capacity assessment when this was considered necessary. Mental Capacity Act awareness training was a mandatory training course and at the time of our inspection 85% of staff had completed the course.

Are Community-based substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. Most clients we spoke with told us that they felt confident to talk to the staff about their treatment and care. Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards clients and staff. Between April and June 2021, staff reported 16 incidents of client aggression and challenging behaviour. Staff directed patients to other services and supported them to access those services properly.

Requires Improvement

Community-based substance misuse services

Whilst all clients told us that they understood that the Covid-19 pandemic meant they could not see staff face to face, they felt that a telephone call once a month with their keyworker was not enough. Four out of the five clients we spoke with told us that the service did not offer many face-to-face groups and most groups were still online. Clients missed the support from seeing their peers in a group setting.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. All clients we spoke with felt the doctors and staff carried out a comprehensive assessment. One client told us that they felt empowered by their doctor to make treatment decisions. The service had also established a monthly involvement group which was facilitated by six people who used the service. In July 2021, the service-user involvement group had developed a partnership with The Tricky Period Project to improve period poverty. As a result, the service stocked free female sanitary products to offer to clients. The group were also planning an end of year celebration which they planned to use as an opportunity to receive client feedback about the running of the service. The service had actively recruited peer mentors, and six clients had a place on the accredited peer mentor course. Service-user reps participated in staff recruitment interview panels.

Staff supported, informed and involved families or carers. The service had a dedicated family, friends and carer team which was led by the safeguarding lead. The team supported young parents as well as carers and families who had a family member who misused substances. The team offered a five-week programme for carers that focused on coping strategies.

Are Community-based substance misuse services responsive?

Good

Access and waiting times

The service's model of care focused on delivering services that members of the public could easily access. The service model was made up of several elements such as 'out there, everywhere'. 'Out there, everywhere' is based around staff delivering a variety of interventions within neighbourhood locations that clients may already access. The neighbourhood teams were located within community buildings, such as GP surgeries, community centres and libraries. Since the service opened it had been focused on embedding the model and training staff. At the time of our inspection, the service was also implementing new clinical pathways to support the overall model of care. The service was moving into five new pathways of care that would provide more specialist support for clients who have different needs. For example, the reclaim pathway, which was for clients who did not use opiates or crack substances. The provider had recruited 30 new staff with a view to start the new clinical pathways by November 2021. Clients or a professional could refer directly into the service either by phone or online.

The provider reported that the model of care had been slower to embed due to the Covid-19 pandemic. The provider told us that face-to-face communication and training with staff had taken longer due to the team not being able to attend on-site at once. At the time of our inspection, the offer for psychosocial interventions (PSI) was mainly online and the variety of interventions was limited in response to the Covid-19 pandemic and to ensure effective infection prevention and control was maintained. However, the provider had clear plans in place to increase the PSI offer and gradually introduce more groups back to face to face but with limited numbers.

The service had a system in place to ensure that clients could seek early support and help. Every day the service allocated a duty manager and duty worker who would be able to respond if a client required telephone support or attended the service. Due to Covid-19, clients were encouraged to attend the service when they had an appointment. Clients told us that reception staff worked hard to ensure clients were given appointments to suit their availability.

The facilities promote comfort, dignity and privacy

The design and layout of treatment rooms supported patients' treatment, privacy and dignity. The service was located within a modern building that provided a full range of rooms and equipment to support treatment and care. There were three treatment rooms and three interview rooms. One of the smaller treatment rooms accommodated the needle exchange. A discreet area of the ground floor was used for urine drug screening. This area had a client toilet and an adjoining testing room to ensure infection control standards were maintained.

The environment included basic furnishings and the décor was clinical looking. The service had a small range of leaflets and signposting information available to take away. A water dispenser was available within the waiting area. Following the inspection, the provider told us that the reception area was kept clear to facilitate cleaning and ensure infection control principles can be maintained.

Meeting the needs of all people who use the service

The service was working to develop and strengthen their offer of care and treatment to ensure it reached all clients including those with a protected characteristic. The service worked in partnership with Antidote, a drug and alcohol support service and MIND which is an independent mental health charity. Antidote is run by people who identify as LGBT. The service had employed two workers from Antidote who targeted their support at hard to reach communities. The workers also had specialist knowledge in chemsex and provided training to the team. Chemsex is the term for when people take drugs before sexual intercourse. The service also employed a female keyworker who worked predominantly with sex workers. During April and June 2021, 126 clients accessed support from the workers. The service had developed links with the sexual health service at the local acute hospital so that the Antidote workers could provide outreach once a week to clients. Staff from MIND were also leading some of the PSI groups on managing difficult emotions and self-care. The service employed a diverse communities engagement lead who worked with male clients who were from black, Asian and minority ethnic communities and misused opiates.

The service could support and make adjustments for people with disabilities, communication needs or other specific needs. The building that the service was located in was accessible for people with disabilities. A suitable toilet was located on the ground floor. Staff made sure patients could access information on treatment, local service, their rights and how to complain although mostly all leaflets available to take away within the service were in English. All members of staff we spoke told us how they knew how to request a language interpreter. The service had an equality, diversity and human rights (EDHR) lead.

The service was open to clients throughout the week. The service operated during core working hours of 9am to 5pm but also held evening clinics once per week. The provider told us that they planned to open on weekends once the Covid-19 risk reduces.

Listening to and learning from concerns and complaints

Whilst the service ensured clients understood how to feedback about the service and treated their feedback seriously, the learning from complaints was not clearly recorded at the quarterly (three monthly) clinical governance meetings or at the monthly team meetings. The provider had received four formal complaints and four informal complaints between June and August 2021. We reviewed the meeting minutes for April and July 2021. Staff had recorded the number of complaints and compliments received, but the meeting notes did not record any learning that had been identified. We

Requires Improvement

Community-based substance misuse services

reviewed a sample of team meeting minutes from February and July 2021 and found that any learning from informal or formal complaints had not been recorded. The lack of recording that complaint outcomes had been shared at team and service level meant that there was no clear way of the provider being able to assure itself that important information had been shared and disseminated across the service.

The waiting area of the service included a feedback box with a survey available as well as a 'you said, we did' board that the provider used to display how they had responded to client feedback.

Are Community-based substance misuse services well-led?

Requires Improvement

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for clients and staff. Leaders understood local issues and the needs of the diverse local population they served, as well as recognising the challenges within their service such as staffing issues. The senior leaders of the service recognised that the team managers required additional support in areas such as supervision and holding difficult conversations with their team. As a result, the provider had put plans in place to for all team managers to attend a development programme.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team. The provider ensured that all staff attended an introductory session with a Turning Point senior leader which included information about the service delivery model and the support available for clients and staff. The service had several development and transformation plans in progress. The plans reflected the provider's vision and objectives for the service. The service aimed to strengthen treatment pathways and introduce a new alcohol treatment pathway that would be led by a team who were experienced in alcohol misuse. Senior managers had been providing on-site support to the service since the provider started operating the service.

Culture

Whilst most staff felt respected and supported, they felt challenged by the high workload caused by the high number of vacancies. The provider recognised that due to the taking over the provision of the service during the Covid-19 pandemic, it had faced some challenges in establishing its operation. Due to the social distancing restrictions, for example, the teams were unable to meet and gain face-to-face support in the working environment. This had impacted on staff morale. The provider had a service wellbeing action plan (WAP) in place, which guided team managers on how to understand the needs of their staff and provide individualised support. The service also planned to carry out a wellbeing assessment with each member of staff by January 2022. The service implemented Friday 'check outs' that were led by a deputy operations manager to ensure staff had an opportunity to communicate directly with a senior leader at the end of the working week. The provider told us that they were keen to implement staff representatives across the service, however, there had been no staff volunteers. The provider thanked staff for their hard work by buying each member of staff a membership card that can be used to receive discounts in a variety of shops.

Governance

Our findings from the other key questions demonstrated that some governance processes were not working effectively. Whilst the provider had monitoring systems in place that assessed service performance, the learning from those assessments were not always shared and responded to in a timely manner. The service had not responded quick

enough to an audit in June 2021 that had identified that 11 clients had been prescribed 100mls or more of an opioid medicine called methadone had not been offered an ECG in the past 12 months. It had also not responded in a timely way to ensure that a backlog of prescriptions had been appropriately voided and discarded. Learning from incidents was not routinely discussed and recorded at team level and staff were not always receiving regular managerial supervision. This meant that staff did not have the opportunity to learn and understand the improvements required. Managers responded to our feedback at the time of the inspection and took immediate action, but the service had not responded effectively at the time of when they had identified a gap.

All services registered with the Care Quality Commission (CQC) are required to notify the Commission of certain incidents, without delay. Whilst the service had notified the CQC of the child and adult safeguarding referrals they had made to the local authority, two of the notifications had not been submitted to the Commission within a reasonable amount of time. One notification had been submitted eight months after the initial safeguarding referral had been made.

Management of risk, issues and performance

Teams had access to the information they needed to manage the service. Leaders of the service identified and escalated relevant risks and issues and identified actions to reduce their impact, such as vacancy rates, although they did not always complete actions promptly or share learning. The service had a local risk register in place that included operational risks such as naloxone distribution and medical reviews. The service's registered manager reported on a quarterly basis to the commissioners and ensured they were cited on the issues that affected the performance of the service.

As part of the service's assurance framework the service carried out audits and specific pieces of work when leaders identified a theme or trend emerging. Senior managers carried out a quarterly 'health check' audit where aspects of the service were reviewed. The last review in June 2021 highlighted incident management and risk assessments were an area for improvement. The areas for improvement were already known to the service and were being monitored through an internal quality review action plan. The service had reduced the number of overdue risk assessments from 94% in November 2020 to 45% in August 2021. The number of overdue medical reviews of more than 12 weeks had reduced from 90% in November 2020 to 51% in August 2021.

Information management

The provider routinely collected performance and training data. The service had systems in place that provided leaders with information about the running of the service. This enabled leaders to maintain clear oversight of the service and identify good practice and areas for improvement.

The service monitored client treatment outcomes and reported these locally and nationally, but staff did not always complete assessments that needed to be reported. Managers were aware of this issue and had plans in place to improve performance. Staff were expected to report on client outcomes using the Treatment Outcome Profile (TOPs). The information was reported via the National Drug Treatment Monitoring System (NDTMS). To complete TOPs, staff are required to carry out an assessment at various intervals of a client's treatment. The performance data for July 2021 demonstrated that 26% of clients had an overdue TOPs of more than six months. As a result of this the service had put various initiatives in place to encourage staff to complete them including individual team targets and team awards. The service was due to review the performance data again in October 2021 at the quarterly clinical governance meeting.

Requires Improvement

Community-based substance misuse services

Engagement

Managers actively engaged with local health providers and community organisations to ensure they met the needs of the local population. The service offered a community navigation service that supported clients to build relationships with community organisations. The service reported in July 2021 that the team had received over 50 referrals. The service also sought opportunities to co locate in community venues across the boroughs, which included providing a prescribing clinic from a local hostel.

The service ensured that they gave staff and clients an opportunity to feedback about the service and be part of service development. An involvement group had been established by people using the service and were actively involved in the recruitment of staff members. The service had issued a staff survey in April 2021, which 41 members of staff completed. The results showed that 88% members of staff trusted and respected their manager and 76% of staff understood how their role contributed to the service. The areas of the survey that scored the lowest included trusting and respecting the leadership team (43%) and staff feeling that the provider prioritises staff wellbeing (43%). The service had a wellbeing action plan in place to support staff and their individual needs.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving the service. The service had been focused on the implementation of the service since they started operating in October 2020. The service was not a member of an accreditation scheme.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured that effective governance processes were in place that enabled leaders to maintain oversight across the service and respond quickly to areas of improvement.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service had not ensured that client records were comprehensive in detail and that clients received the required health checks including an ECG if they were prescribed over 100mls of methadone.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider had not ensured that the Care Quality Commission was notified of all incidents requiring notification, without delay.