Turning Point Oxfordshire

Quality Report

Rectory Centre
27-29 Rectory Road
Oxford
OX4 1DU
Tel: 01865 261 690
Website: www.turning-point.co.uk/oxfordshire-roads-to-recovery

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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	Outstanding ☆
Are services safe?	Outstanding ☆
Are services effective?	Outstanding ☆
Are services caring?	Good ●
Are services responsive?	Good ●
Are services well-led?	Outstanding ☆

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 Turning Point Oxfordshire as outstanding because:

- People were protected by a strong, comprehensive safety system, with a focus on openness, transparency and learning. The provider had systems and processes that ensured the service was safe, with good staffing levels and skilled staff to deliver care. The service ensured that risk to clients was well assessed and well managed, and that good quality harm reduction interventions were offered at every engagement. The service ensured that clients at the highest risk of harm were pro-actively engaged and received a high standard of care, as well as those who were closer to completing their treatment and achieving their recovery goals.
- Outcomes for people who used the service were consistently better than expected when compared with other similar services**.** The service delivered treatment in line with up to date best practice guidelines, including the segmentation of the opioid substitution caseload according to clients' stages of change. Opioid substitution therapy is the use of medicines like methadone and buprenorphine to treat physical dependence on opiate drugs like heroin, and this approach meant that the treatment people received was tailored to meet their needs. The service showed a real commitment to interagency team work which had led to and successful innovations to meet the needs of offenders, homeless clients, clients with a dual diagnosis and people requiring treatment for hepatitis C.
- Staff treated and supported people with dignity and respect, and involved them as partners in their care. The service was caring, with staff consistently demonstrating compassion, respect and understanding for clients. Clients gave overwhelmingly positive feedback about their treatment, the relationships they had with staff and the changes they were able to make as a result of their support. Clients described the service as offering more than just treatment; it also offered activities that helped them with their overall wellbeing.
- People's needs were met through the way the service was organised and delivered. The service was responsive to the needs of clients and stakeholders, with an excellent programme of engagement with the wider community and a range of aftercare options for clients in recovery, especially with regard to training and employment.
- The leadership, governance and culture of the service were used to drive and improve the delivery of high quality person-centred care. The service was very well led, with robust governance systems that ensured high level risk was well managed and a culture of learning and continuous improvement was promoted. Staff were well supported, had high morale and felt a strong connection to the parent organisation.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services		Outstanding

Summary of findings

Contents

Outstanding ☆

Location name here

Services we looked at
Substance misuse services

Summary of this inspection

Background to Turning Point Oxfordshire

Turning Point Oxfordshire (Roads to Recovery) is contracted by Oxfordshire County Council to deliver a range of community-based substance misuse services within Oxfordshire.

The service operates an integrated drug and alcohol service in four locations. The main office is in Oxford city centre, and the remaining three 'hub' locations are in Didcot, Banbury and Witney. We inspected all four hubs as part of this inspection.

At the time of our inspection, the service employed the equivalent of 78 full time members of staff (this includes part time workers).

The service offers a range of treatment and aftercare services; pharmacological treatment (opioid substitution therapy and alcohol detoxification), harm minimisation services (needle exchange, overdose prevention, advice, and screening for blood borne viruses), in-practice GP addiction nurses and/or recovery workers (shared care), and structured one-to-one and group work. The service assesses clients for residential rehabilitation and detoxification, manages their placements and provides aftercare when they return to the community. The service also offers open access sessions, parenting support, support for parents and carers, employment and training advice and support, facilitated access to mutual aid, relapse prevention and recovery support, and a social enterprise café.

The service operates satellite services in Henley and Bicester, along with mobile outreach services to smaller communities around the county.

There was a registered manager in place.

The service was registered with CQC on 07 April 2015 and provides the regulated activity of treatment for disease disorder or injury.

We previously inspected this service in February 2016. Services were not rated at this time

Our inspection team

The team that inspected the service comprised two CQC inspectors and two specialist advisors. Both specialist advisors were registered mental health nurses and qualified non-medical prescribers with experience of working for substance misuse services.

Why we carried out this inspection

We undertook an unannounced, comprehensive inspection of this service as part of our routine programme of inspecting registered services.

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?

Summary of this inspection

Before the inspection visit, we reviewed information that we held about the service. During the inspection visit, the inspection team:

- visited the four hub locations; Oxford City, Banbury, Didcot and Witney
- spoke with 20 clients of the service, including three peer mentors
- reviewed care records for 12 clients
- reviewed five staff supervision files
- carried out a tour of all four service locations, including inspections of clinic and treatment rooms
- observed two multi-disciplinary team meetings across two hubs
- observed a recovery skills group attended by six clients
- observed an engagement clinic session
- interviewed 19 members of staff, including the registered manager, a deputy operations manager, a nurse manager and non-medical prescriber, a hub manager, a GP with special interest (GPSI), a clinical psychologist, a safeguarding coordinator, two senior recovery workers and nine recovery workers including an outreach lead.
- gathered feedback from 12 key stakeholders, a crown court judge, a police anti-slavery lead, a local authority community safety manager, three managers of local housing and homelessness organisations, a child protection social worker, a care coordinator from the local adult mental health team, a consultant psychiatrist from the local NHS trust, a hepatology specialist from the university teaching hospital, a dual diagnosis lead from a mental health housing organisation, and a prison drug treatment manager
- reviewed service documents including minutes of service user involvement meetings, safeguarding audits, clinical audits, equality and diversity audits, engagement clinic audits, staff training and supervision audits, a sample of staff files, minutes from multi-agency meetings including panels to safeguard sex workers and repeat victims of domestic violence, and minutes of service user involvement meetings
- reviewed key operational policies, including safeguarding children and vulnerable adults, prescribing protocols and pathways for clients with a dual diagnosis and blood borne viruses.

What people who use the service say

Clients gave overwhelmingly positive feedback about their treatment, the relationships they had with staff and the changes they were able to make as a result of their support. We spoke with clients receiving treatment for alcohol, cocaine and heroin misuse, and with people at different stages of recovery. All said that engaging with the service had made a positive difference to their lives. Clients from the Banbury hub in particular emphasised that the service was a safe place to receive informal support and had helped them maintain recovery goals. Several clients said that their recovery worker had helped them to achieve goals beyond their drug or alcohol use, for example, housing, physical health and offending behaviour. Clients commented that all staff knew their names and were welcoming, not just their own key-worker. Clients described the service as offering more than treatment but also activities that helped them with their overall wellbeing.

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?

Outstanding 

We rated safe as outstanding because:

- People were protected by a strong comprehensive safety system, with a focus on openness, transparency and learning. The service was in high demand and had excellent case management processes that ensured all clients received high quality care.
- All hub facilities were clean, safely managed and well equipped.
- The service was fully staffed and consistently provided good levels of medical cover. Mandatory and specialist training was up to date for all staff.
- Risk was assessed very well and managed by a multi-disciplinary team and with the involvement of other key agencies. The service was well integrated into multi-agency risk management initiatives, where people at high risk of harm from domestic violence, modern slavery, street sex working or rough sleeping were monitored and supported.
- Clients in crisis were actively supported by staff to remain in treatment and to keep safe.
- The service operated a “script in hand” system, which meant that the large caseload of opioid substitution therapy clients had face to face contact with a member of staff, every two weeks. This enabled good monitoring of compliance with medication and of clients’ wellbeing.
- The service followed protocols for alcohol detoxification that were in line NICE guidelines and ensures that health risks were well assessed and monitored appropriately.
- Harm reduction advice and information was provided at every contact, including safer injecting advice, advice around overdose prevention and provision of Naloxone kits. Naloxone is a drug that can be used in an emergency to reverse the effects of an opiate overdose and save lives.
- The service ensured that all clients requiring screening and vaccination against blood borne viruses were encouraged to do so, had high levels of up-take and of engagement in hepatitis C treatment if positive. Clients health was actively monitored by appropriately qualified clinicians.
- Staff stored all client information on a secure electronic case management system, to which all staff had access and were trained to use.

Summary of this inspection

- The service had effective policies, procedures and training related to medication and medicines management.

Are services effective?

Outstanding 

We rated effective as outstanding because:

- The service's performance data showed consistently excellent outcomes achieved by clients, with higher numbers completing their treatment and not needing to return within six months than other comparable services nationally.
- The service had established a highly innovative treatment pathway to test and treat clients for Hepatitis C, with high rates of successful treatment completion. The service had been cited as an example of good practice in National Hepatitis C forums. Clients were able to receive their treatment in the familiar setting of the hubs, rather than attending the main hospital, removing a major barrier to accessing treatment and leading to excellent treatment outcomes.
- The service placed a high emphasis on staff training, and had invested heavily in training and support around continuing professional development for staff. The service had funded four nurses to qualify as non-medical prescribers, 14 staff to complete NVQ 3 in health and social care, and 4 staff to complete NVQ Level 5 in leadership and management. The high level of expertise within the service enabled them to offer clinical placements to trainee doctors, nurses and social work students, and delivered training to stakeholders across the county.
- The service demonstrated excellent interagency team work. The service developed pathways and models to ensure high quality care for clients with mental health problems through a well- developed dual diagnosis pathway. There was an innovative and well-developed pathway for offenders subject to Drug Rehabilitation Requirement orders managed jointly with a crown court judge, probation and a prison. Both were highly praised by stakeholders as models of good practice and had shown very good outcomes for clients.
- The service had effective protocols in place around care shared between the hub and client's GP practices and with pharmacies.
- Clients received holistic assessments of their strengths and needs; they were allocated a key worker and had a holistic recovery plan that promoted recovery and met the individual

Summary of this inspection

needs of each person. Care coordinators were clearly identified, and all clients we spoke with knew who their key-worker was. Clients were supported to access residential detoxification and rehabilitation services through a well-defined pathway.

- The service actively sought to re-engage clients who exited treatment prematurely through extensive outreach work.
- The service continuously audited service provision and outcomes of people's care and actively sought involvement from service users, and their families and carers where appropriate and made appropriate changes based on this.
- We found evidence of good practice in applying the Mental Capacity Act, with considerations of capacity to consent being impaired by mental illness and / or intoxication in care records and clinical meeting minutes.

Are services caring?

Good

We rated caring as good because:

- Clients we spoke with said that staff were knowledgeable, understanding, supportive, encouraging and non-judgemental. They said that staff treated them with dignity and respect, and that they were able to speak to staff privately. All hubs were described as a safe place to receive informal and peer support. Several clients said that their recovery worker had helped them to achieve goals beyond their drug or alcohol use, for example, housing, physical health and offending behaviour. Clients commented that all staff knew their names and were welcoming, not just their own key-worker.
- All staff we encountered spoke about clients with warmth, respect and positive regard.Clients told us that staff were always friendly and welcoming. Staff avoided the use of stigmatising language and showed a high level of understanding and compassion for the causes and consequences of people's substance use. We observed exclusively positive interactions between staff and clients.
- All staff had completed training in equality and diversity. The service also carried out annual equality and diversity audits and had clear action plans in place to address any areas identified for improvement.
- Staff supported clients to celebrate their successes in reaching their recovery goals with their peers if they chose, and to share messages of encouragement and support through a book of messages.

Summary of this inspection

- Clients were involved in their care planning and said that staff helped them to think through different options to consider what would be best for them. The service sought feedback through service user involvement meetings and suggestion boxes placed in waiting areas and produced a service user newsletter for each hub.
- Staff supported clients to maintain and improve their family relationships through individual care plans, and through parenting groups run for clients with children.
- Clients told us that their family members had been involved in their care as requested.

However:

- The service did not have a families and carers forum, although staff told us that this was in planning stages at the time of the inspection.

Are services responsive?

Good

We rated responsive as good because:

- The service actively promoted positive engagement with the wider community through a peer led programme of volunteering activities to improve the recovery outcomes. The service had recently held a coffee morning to raise money for a cancer charity. The social enterprise café also provided an interface with the local community, and was specifically funded to enable offenders with substance misuse issues into employment. These activities were well publicised in the local community, with positive local press coverage that raised awareness of the service for people who needed it and served to challenge stigma around people with substance misuse problems.
- The service had established a clinic timetable and process for gathering medical information that ensured minimal delay between referral, assessment and start of treatment. We saw examples of assessments, prescription starts and medical reviews taking place within 24 hours, and of waiting times for prescribing rarely exceeding seven days. We observed clients at high risk or harm and hard to engage clients being able to re-enter treatment quickly, through staff responding flexibly according to their need. The clinic timetable also offered a choice of times for clients in the core caseload to attend, and evening appointments for clients in employment.
- The service had developed successful protocols for supporting specific groups of people, in particular, homeless clients and offenders subject to Drug Rehabilitation Requirements (DRRs).

Summary of this inspection

The outreach lead accompanied street outreach staff on early morning outreach sessions and operated in-reach satellites in local homelessness services. The service had committed resource to join a "one-stop-shop" for homeless people based in the city centre. In order to improve engagement levels and overall outcomes for the DRR cohort, the service had established a rehabilitation programme that enabled clients to be regularly and comprehensively reviewed jointly by the service and the crown court judge overseeing their order, and to transition directly from prison in to residential treatment where appropriate. Attendance at progress reviews was reported by the judge to be extremely high.

- The service had clear eligibility criteria which was well publicised and understood by other agencies. The service had alternative care pathways and referral systems in place for people whose needs could not be met by the service. The service had an agreed response time for accepting referrals, completing an assessment and starting treatment specified in their contract with the local authority, and consistently exceeded its targets. The service offered evening and weekend services, to meet the needs of clients and safe, age-appropriate spaces for the children of service users.
- The service responded promptly to people being released from prison, offering initial assessment and bridging prescriptions as needed. A dedicated engagement lead and clinic ensured that clients at greatest risk of harm and of dis-engagement from treatment were pro-actively engaged in treatment, offering blood bourne viruse screening and providing Naloxone training and kits. Engagement clinics were structured to avoid fixed appointment slots, which had been found to be hard to manage for clients still using substances.
- A dedicated recovery clinic for clients who were close to treatment completion was scheduled at the end of the week, to offer additional motivational support in advance of the weekends and to limit contact with other clients who may still be actively using substances. Clients and peer mentors told us that this helped them to feel safe in the service.
- Staff communicated with clients via their preferred methods, for example, emails or text messages. The service operated regular satellite clinics and mobile engagement programs, as an adjunct to the four main hub offices.
- The hub facilities had full disabled accessibility and a selection of rooms that were used for a wide variety of purposes, with an extensive selection of information on offer. All clients we spoke with said they found the hub locations welcoming and

Summary of this inspection

comfortable. However, one carer fed back that having one entrance placed abstinent clients at risk through them having contact with clients who were still using substances. Managers of the service fed back that where this was a concern appointment times could be and had been adjusted.

- Education and work activities were actively supported by staff for clients at the appropriate stage of their recovery. The service had three dedicated education, training and employment (ETE) workers who were present in each hub two to three days per week.

However:

- Our last inspection highlighted a lack of specific support for black and minority ethnic (BME) clients and those from the lesbian, gay, bisexual, transsexual, queer (or questioning) (LGBT+) community. The service planned to undertake some BME specific outreach and engagement work, and develop pathways and a joint training programme to support LGBT+ clients. However, these initiatives were still in planning stages at the time of our inspection.

Are services well-led?

Outstanding ☆

We rated well-led as outstanding because:

- The service had a clear leadership structure that incorporated senior clinical leadership. Leaders had the skills, knowledge and experience to perform their roles, with significant experience in managing community substance misuse services. Leaders were visible and accessible within the service and could be easily approached. There were clear quality assurance, management and performance frameworks in place that checked the service's compliance with operational processes.
- The parent organisation, Turning Point, is a large national provider of health and social care services for people with learning disabilities, mental health and substance misuse issues. The organisation had a 5-year corporate strategy that underpinned the delivery of the service. Staff knew and understood the vision and the values of the service and understood their own roles in achieving it. The organisation recognised success within the service, which had won an award for having the highest levels of performance in the organisation.
- The service invested heavily in the learning and development of staff, which benefitted clients through the maintenance of a stable, motivated and highly skilled staff team

Summary of this inspection

- Overall, a systematic approach was taken to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money. The service placed a high emphasis on the importance of working collaboratively with a wide range of partners, providing lead staff members and investing time and resource in building safe, innovative pathway models which led to good outcomes. Leaders of stakeholder organisations spoke very highly of the partnership approach the service took to innovation and problem solving, and praised the service leaders for their communication and strategic approach.
- The organisation encouraged creativity and innovation to ensure up to date evidence based practice was implemented and embedded. The segmented approach to managing clinics, the blood borne virus pathway, the dual diagnosis pathway and integrated offender treatment model were all very successful examples of safe innovation meeting the particular needs of the client group. New innovations were well planned and managed with stakeholders and there was significant commitment from front line staff who were empowered to lead and develop beyond their basic job descriptions.
- Staff demonstrated a sense of ownership and pride in their own part of the service whilst clearly explaining how It fitted into the wider picture. All staff we interviewed spoke very highly of the culture within the service and the wider organisation, drawing comparisons with others they had worked within and describing it as the best.
- Externally, the service participated actively in county-wide forums including the controlled drugs local intelligence network, domestic homicide reviews and inquests. The service held quarterly morbidity and mortality meetings jointly with the local authority public health team.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

The service had an audit system in place to ensure compliance with the Mental Capacity Act 2015. All staff training was up to date, and clients' capacity was consistently considered and documented at the time assessment. Training and guidance on assessing capacity was provided from within the clinical leadership team by the consultant psychiatrist. Staff were able to describe how the act applied in practice within their client group, for example, capacity fluctuating due to episodes of poor mental health or intoxication from substances.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Substance misuse services	☆ Outstanding	☆ Outstanding	Good	Good	☆ Outstanding	N/A
Overall	☆ Outstanding	☆ Outstanding	Good	Good	☆ Outstanding	☆ Outstanding

Notes

Substance misuse services

Safe	Outstanding ☆
Effective	Outstanding ☆
Caring	Good ●
Responsive	Good ●
Well-led	Outstanding ☆

Are substance misuse services safe?

Outstanding ☆

Safety of the facility layout

All hubs had well-equipped clinic rooms with the necessary equipment to carry out physical examinations. All hub environments were safe, free from hazards and well lit. All appropriate health and safety records were present and in order, and the service had an up to date Health and Safety and Fire Risk Assessments in place. Personal alarms were carried by staff according to assessed risk.

Maintenance, cleanliness and infection control

All areas were clean and well-maintained. Several clients commented on feeling safe and comfortable in services. Staff adhered to infection control principles, including handwashing and the disposal of clinical waste, for which the service had a contract in place with a suitable provider.

Staff ensured that clinic room equipment (scales, blood pressure monitor, first aid and blood spillage aid kits) were regularly checked and well maintained. Supplies were well organised and in date. Fridge and room temperatures were correct and also regularly checked.

Drugs were stored appropriately in locked cupboards and in accordance with national guidance, and information about hand hygiene and needlestick injuries were clearly displayed. Clinical waste, including sharps, were appropriately disposed of. No controlled drugs were stored on the premises.

Safe staffing

At the time of our inspection, 1349 people were receiving treatment from the service. Of these, 705 were accessing the Oxford city hub, 287 were attending the Banbury service, 250 attended Didcot and 107 attended Witney. Of these clients, 125 were receiving treatment for alcohol only, 801 for heroin and/or crack and 68 for other drugs like cannabis and new psychoactive substances. There were 355 clients whose care was shared between the service and dedicated GPs across the county. The average caseload for staff in the city centre and Banbury hubs was 26 clients, and lower for the other two locations. All hubs were well staffed, with consistently safe levels of staffing in place. Staff told us that caseload numbers were at a level that enabled them to provide good, safe care to each individual client. We found levels of medical cover across all hubs were consistently sufficient to ensure good, safe care.

Bank staff were available through the wider organisation if required. However, none were being used at the time of the inspection as the service was fully staffed. At the last inspection the service had been relying on temporary staff to fill key clinical and no-clinical roles, however no agency staff had been used in the two years prior to this visit.

Staffing levels and mix

All four teams had enough staff to meet the needs of clients, and management had contingency plans to manage unforeseen staff shortages. In the event of short notice requirement for medical staff, management informed us that qualified staff from other services within the organisation could be deployed.

Staff and managers informed us that caseload numbers were at a level whereby if a member of staff was absent through sickness or other leave their clients could be supported by colleagues.

Substance misuse services

Staff and clients told us that the service was always well staffed, and that activities were very rarely cancelled. One client mentioned an occasion when a service user involvement meeting was cancelled due to staff sickness, but that the clients met together for peer support on that occasion.

Data from the service showed that the service had generally maintained a full complement of staff over the 12 months leading up to the inspection, with a low turnover, no vacant medical posts, and low sickness levels of 2.5%.

The service had a pro-active approach to identifying future shortages of staff; for example, through the recruitment of student nurses and through the in-house training and development of existing staff. This included supporting four nurses to gain non-medical prescribing qualifications, and recruiting nurses without experience of substance misuse, including those newly qualified, and investing in training and support for them to gain specialist knowledge and skills within the organisation.

Mandatory training

Staff had completed mandatory health and safety awareness training, and had completed training in and understood their responsibilities in relation to the Mental Capacity Act 2005. New staff completed an induction program and were then assessed for their level of competence.

Assessing and managing risk to clients and staff

During the inspection we reviewed 12 care and treatment records. The sample included clients on the engagement, core, maintenance and recovery caseloads, and included clients in treatment for a range of substances. All had comprehensive risk assessments in place and evidence of crisis planning, including evidence of overdose awareness and Naloxone training and kits for opiate clients.

Care records clearly identified new and emerging risks, including increased drug use or change to route of admission (for example, injecting rather than smoking substances), and we saw evidence of on-going risk assessment and treatment plans being adjusted accordingly, often after discussion in multi-disciplinary team meetings.

Assessment of client risk

We observed clients attending the engagement clinic who were experiencing crisis being actively supported by staff to remain in treatment and to keep safe. We observed staff responding quickly to clients who had presented to the service unexpectedly after a period of disengagement, and arranging for their treatment to be re-started.

We observed discussions in multi-disciplinary team meetings and reviewed minutes of key meetings that showed staff identifying and responding to deterioration in people's health, including mental health, escalation of drug use or offending behaviour.

We found that staff involved other key agencies, including homelessness and mental health services, sharing information effectively. We found that staff routinely sought and obtained background information from other services to ensure they had sufficient information to comprehensively assess client risk, including reports from probation, prison, clients' GPs, community safety and mental health teams. Where there were delays in obtaining this information, we found that the staff made efforts to ensure that this did not delay treatment starting, and put in place contingency plans for the interim period, for example, having an additional member of staff present to support a colleague.

Management of client risk

The service ensured that risk to service users was well managed. The service had undertaken work to segment the service caseload and group clients according to their need and stage of recovery, and tailored the delivery of the service to meet their needs. This included the identification of clients at highest risk of harm, and a focussed approach to engaging these individuals in treatment through a weekly engagement clinic overseen by a dedicated senior recovery worker. Similarly, clients who were closer to treatment completion and abstinence were supported through recovery sessions scheduled at the end of the week. This is in line with national good practice guidelines.

The service operated a "script in hand" system, which meant that all opioid substitution therapy clients had face to face contact with a member of staff every two weeks. This enabled good monitoring of compliance with medication and of clients' wellbeing. The service followed protocols for alcohol detoxifcation that were in line NICE guidelines and ensures that health risks were well assessed and monitored appropriately. This included robust

assessments of clinical suitability for a community based detox and ensuring that nurses had full medical histories and consent to share information with clients' GPs prior to beginning treatment.

We found that service users were made aware of the risks of continued substance misuse with harm minimisation and safety planning forming an integral part of recovery plans. For example, data from the service showed that 767 Naloxone kits had been distributed in the twelve months prior to the inspection. We saw evidence of harm reduction advice and information being provided at every contact, including safer injecting advice and advice around overdose prevention.

The service ensured that all clients requiring screening and vaccination against blood borne viruses were encouraged to do so. In the twelve months prior to the inspection the service had screened 296 clients, and vaccinated 109 against Hepatitis B. The service had sufficient nursing cover to enable full blood tests to be carried out as required, however the hepatology nurse based in the service provided training and support for non-clinical staff to carry out dry blood-spot testing and give clients their results. The service then provided treatment for hepatitis C in-house.

We observed excellent multi-agency work in managing client risk. The service had a dedicated outreach worker who was embedded in external teams engaging with rough sleepers, street drinkers and staying in homelessness services, providing harm reduction interventions, taking action to safeguard clients and working hard to engage hard to reach individuals into treatment.

Staff from the service were active members of a multi-agency panel to work with clients who were sex working, sharing information appropriately to engage vulnerable women and enable them to stay in treatment. The service supported victims and perpetrators of domestic violence as members of multi-agency panels, sharing information about clients that enabled other services to monitor and manage risk. The service's dual diagnosis pathway with the adult mental health team (AMHT) enabled mental health risks to be well managed jointly.

Staff adhered to best practice in implementing a smoke-free policy, with no smoking in the vicinity of the building. The service had robust safety processes, including the use of on-site personal safety alarms and lone working procedures for outreach work.

Safeguarding

We found that the service worked effectively within teams, across services and with other agencies to promote safety including systems and practices in information sharing. Staff proactively engaged in safeguarding activities (both children and vulnerable adults) to support clients. At the time of our inspection, 65 clients had children with child protection plans, and referrals were routinely made to adult and children's social care around safeguarding. Staff had made 1497 enquiries to the Oxfordshire multi-agency safeguarding hub in the 12 months leading up to the inspection.

All 12 care records reviewed, showed staff had asked about contact with children, and where service users did have contact with children, this was recorded and a safeguarding assessment was present.

Two dedicated safeguarding leads provided support for the staff teams, chairing monthly safeguarding meetings for staff to bring cases for discussion. The leads audited all safeguarding cases on a monthly basis. The managers of the service carried out safeguarding audits every eight weeks. The service operated a dedicated safeguarding clinic on a weekly basis with eight weekly reviews carried out by the safeguarding coordinator and a nurse prescriber.

We observed discussions between staff and clients with children about their attendance at the service. This formed part of an action plan agreed with their children's social worker to address their substance misuse. We saw that information sharing for these cases was well managed by staff and that clients understood what information would be shared and for what purpose.

Safeguarding information was visibly displayed in waiting rooms for service users to refer to if needed.

Staff had up to date safeguarding training for both vulnerable adults and children and young people, which was mandatory and delivered both in-house and by local safeguarding boards. All staff were trained up to Level two

in safeguarding, and some up to level three, depending on their role. Staff we interviewed were aware of how to identify potential abuse and neglect and how to refer as necessary.

The provider had effectively assessed and managed risks associated with child visitors to the hubs.

We saw evidence of good multi-agency work around safeguarding adults, in particular through partnership with local police to identify and support victims of modern slavery, and through active membership of a local multi-agency panel to engage sex workers. Stakeholders highlighted to us the effectiveness of the working relationship with the service and the positive outcomes achieved for the vulnerable adults.

Staff access to essential information

Staff stored all client information on a secure electronic case management system, to which all staff had access and received training to use. The system was quickly accessible to all staff and contained live information about all aspects of a client's treatment, including their prescribing regime if they had one.

Key risks, including children, were clearly flagged, as were clients who were due a review or were at risk of disengaging. Staff handed over key information through morning briefings and ad hoc "flash" meetings, as well as via the care notes system which all staff had access to.

Medicines management

The service had effective policies, procedures and training related to medication and medicines management including, prescribing, detoxification, assessing people's tolerance to medication, and take-home medication including naloxone.

The service used pharmacy checks as part of the process of checking clients' engagement and compliance with medication. Staff reviewed the effects of medication on clients' physical health regularly and in line with National Institute for Health and Care Excellence guidance, especially when the client was prescribed a high dose medication, when additional medical monitoring was required.

We reviewed medicine audits for all four hubs, that had been carried out in accordance with the organisational medicines administration procedure and determined what should be done at each stage of the medicine ordering, handling, storage and administration process.

The clinic room audit we carried out found medicines were in date, safely stored in locked cupboards or refrigerated at correct temperatures. Each hub completed self-assessments, to ensure good practice and prevent harm to clients.

Track record on safety

The service had experienced no serious incidents in the 12 months prior to the inspection.

Seven people known to the service had sadly died in the 12 months prior to the service. In each case the deaths were reported to CQC and investigated by the organisation as part of their clinical governance processes, with no deaths being drug related.

The service had not been the subject of any prevention of future death reports by the coroner, however had been commended in a report to a partner organisation for their levels of care and dual diagnosis work relating to the perpetrator of a homicide.

Reporting incidents and learning from when things go wrong

All staff knew what constituted an incident and how to report them. All staff referred to the electronic risk management system as the way of reporting incidents and understood how information was escalated within the service, the organisation and to external bodies like the local authority and the CQC. Staff we interviewed were clear about their roles and responsibilities for reporting incidents, and described being supported and encouraged to report. Staff described ad hoc debriefing meetings following an incident and understood the importance of completing reports in a timely way.

Staff understood the duty of candour, which was clearly referenced in the organisations policy on incidents. This meant that the service was committed to being transparent and offered an apology when things went wrong.

The clinical governance group met quarterly to review incidents and share learning. Management provided support to staff following incidents, acted on the findings of

investigations and gave feedback to staff and people who use services after incidents. We observed robust clinical discussions about risk in multi-disciplinary team meetings, and saw evidence of these discussions in clients care notes.

The service experienced very low numbers of incidents relating to clients, despite a high volume of clients visiting the service for their prescriptions on a weekly basis (up to 400 people per week at the city centre hub).

The service promoted an open culture through effective whistleblowing procedures, and staff told us that they knew who to escalate concerns to and how to apply the whistleblowing procedure if necessary.

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

Outstanding ☆

Assessment of needs and planning of care

We reviewed 12 care records as part of this inspection. We found that staff completed a comprehensive assessment in a timely manner, and developed care plans that met the needs identified during assessment. All 12 recovery plans identified the person's key worker/care co-ordinator. We found that clients were allocated a key-worker according to their individual needs and stage of recovery, which determined which caseload they would begin treatment on.

Individual needs and recovery plans, including risk management plans, were regularly reviewed by staff. We reviewed case management audit paperwork for the engagement cohort, noting that where care plan or risk assessment reviews were out of date, this was by no more than four days and due to clients not attending. The engagement lead was able to describe firm plans to reach these clients and when the care plan would be updated. We reviewed two clients' journeys from the engagement cohort, to the core service and on into recovery, progressing through the service as set out in their care plan. We also saw evidence of clients entering treatment and moving directly onto the core caseload, according to their assessed need.

All care records included a risk management plan for those people identified as being at risk that included a plan for unexpected exit from treatment. We noted that all clients attending the engagement clinic for the first time were offered a Naloxone kit with training and a screen for blood borne viruses (BBV) there and then, rather than being offered another appointment and risk disengagement.

The service had established a clinic timetable and process for gathering medication information that ensured minimal delay between referral, assessment and start of treatment. We saw examples of assessments, prescription starts and medical reviews taking place within 24 hours, and of waiting times for prescribing rarely exceeding seven days. We observed clients at high risk of harm and hard to engage clients being able to re-enter treatment quickly, by staff who knew their histories and responded quickly and flexibly when they presented to the clinic. The service responded promptly to people being released from prison, offering initial assessment and bridging prescriptions as needed. This ensured that clients at highest risk of accidental overdose were kept safe. A dedicated engagement lead and clinic ensured that clients at greatest risk of harm and of dis-engagement from treatment were pro-actively engaged in treatment, BBV screening and provided with Naloxone training and kits.

A dedicated recovery clinic for clients who were close to treatment completion was scheduled at the end of the week, to offer additional motivational support in advance of the weekends and to limit contact with other clients who may still be actively using substances. Clients and peer mentors told us that this helped them to feel safe in the service.

Best practice in treatment and care

The service had established a highly innovative treatment pathway to test and treat clients for Hepatitis C, with high rates of successful treatment completion. The service had been cited as an example of good practice in National Hepatitis C forums. Two hepatology nurses provided coverage across the four hubs, Monday to Friday. In the 12 months prior to the inspection, 43 clients had started treatment for Hepatitis C, and 33 had successfully completed. Staff and clients told us that being able to receive their treatment in the familiar setting of the hubs, rather than attending the main hospital, removed a major barrier to clients accessing treatment for their hepatitis.

The service had set up an independent social enterprise business that offered training and employment

opportunities for clients. The Refresh café close to the Oxford city hub enabled current and former clients, including clients on day release from an open prison, to gain work experience and qualifications. Clients and peer mentors told us that this was highly valued. This aspect of the service meets with NICE quality statement 23, "People in drug treatment are offered support to access services that promote housing, education, employment, personal finance, healthcare and mutual aid."

The service actively sought to re-engage clients who exited treatment prematurely through outreach work (including the local night shelter and street outreach), work with partnership services like the adult mental health team and multi-agency panels, and attempts to reach clients by telephone and letter. Three clients we interviewed described their key-worker contacting them more than once if they had begun to disengage, and said that this made them feel the staff cared about them.

The service provided an on-line recovery tool offering evidence based advice and motivational support, which clients could access in the service as part of a group activity and independently from their own electronic devices. This is line with NICE QS 23, "People in drug treatment are offered appropriate formal psychosocial interventions and/or psychological treatments." The service also provided the "Oxfordshire Wellbeing Cloud", an on-line resource for the county offering advice, support and referral for clients and professionals.

All care records we reviewed showed recovery plans that promoted recovery and met the individual needs of each person. This included physical and psychological health and social needs (for example housing, education and employment, family, faith, legal and financial support) and incorporated existing recovery plans. Client records clearly recorded treatment rationales in line with NICE. prescribing and detoxification guidelines.

The service was able to refer clients to psychological therapies recommended by NICE, through IAPT (Improving access to psychological therapies). The service's dual diagnosis pathway included a treatment pathway for clients receiving recovery support to access talking therapies to improve their overall psychological health.

The recovery skills group work programme was based on cognitive behavioural therapy (CBT)) and models of psychosocial intervention (MOPSI)). This is line with NICE QS 23, "People in drug treatment are offered appropriate formal psychosocial interventions and/or psychological treatments." We observed a recovery skills group attended by clients at varying stages of treatment and using different substances, including alcohol. We observed the group facilitators drawing clear connections between the thoughts, feelings and actions described by the clients and the theoretical models described in the group work material. We observed clients being supported to gain insight into their thinking patterns that affected their drink and drug using behaviour, in a respectful and supportive environment. The service also hosted 12 step fellowship meetings (Alcoholics Anonymous and Narcotics Anonymous), also known as mutual aid, within the hubs and actively supported clients to attend. This is in line with Public Health England (PHE) recommendations, "Improving Access to Mutual Aid", 2013.

Health screening was routinely conducted as part of alcohol and opioid substitution treatment. For example, titration, physical observations and baseline blood tests were carried out by qualified nurses to help inform appropriate treatment, including when prescribing and detoxification regimes.

Care records showed that staff routinely gained clients' medical histories from their GP, and were routinely in direct contact with GPs, ensuring that pharmacological treatment interventions were carried out safely. Health screening was routinely conducted as part of alcohol and opioid substitution treatment. For example, titration, physical observations and baseline blood tests were carried out by qualified nurses to help inform appropriate treatment, including when prescribing and detoxification regimes.

The service had a protocol in place for the transition of young people into the service in relation to opioid substation therapy. The managers informed us that this was rarely required, but that a clear process existed that was followed jointly with the young person's substance misuse service and was closely supported by a safeguarding coordinator.

Monitoring and comparing treatment outcomes

The service's performance data showed consistently very good outcomes achieved by clients, with higher numbers completing their treatment and not needing to return within six months. than other comparable services nationally. Public Health England outcome data showed

the service to be the third highest performing service for clients stopping their opiate use in their comparison group, with very low numbers re-presenting to the service (6 in 12 months). For non-opiate users (for example, people needing treatment for cannabis or cocaine), the service was in the top quartile of their comparison group. For alcohol users, the service was the highest performing service in their comparison group.

The service was benchmarked against other services within the parent organisation, and was widely recognised as a very high performing service. The commissioners review commended the service's high performance, rating it as green (adequate to good, or better) across 10 domains; leadership and management, staffing levels and recruitment, staff skills and training, approach to personalisation, care plans and risk assessments, health and safety, safeguarding, service quality and quality assurance (including complaints), user views and involvement, and partnership working.

As part of this inspection we reviewed quality monitoring report following a review carried out by Oxfordshire County Council Public Health. The review stated that since the contract had begun, the performance against the key contractual outcomes had dramatically improved, that the service was meeting all key performance indicators, and in most cases achieving stretched targets. The report also confirmed that the service was placed within the top quartile of services nationally.

The service continuously audited service provision and outcomes of people's care and actively sought involvement from service users, and their families and carers where appropriate and made appropriate changes based on this. A single case management system was used by all staff and could provide information in real time to audit all aspects of clients' treatment, individually and by caseload or cohort. The service regularly audited by cohort, i.e. engagement, core, maintenance, recovery and safeguarding, to ensure that all necessary actions had been completed.

All staff were engaged in the monitoring and improving of outcomes, through discussion in team meetings and through visual displays in the service showing the number of people successfully completing their treatment. Staff we interviewed described the service as being outcome focussed, in motivating clients to achieve sustained recovery, while also ensuring high quality harm reduction interventions were offered for those that needed them.

Skilled staff to deliver care

The staff team had a collectively high level of qualifications and experience and had adapted well to the demands of operating a "one-stop shop" service. The service employed a full range of qualified clinicians, including a consultant psychiatrist, nurses and nurse managers, a prescribing pharmacist, a clinical psychologist, and a doctor. Non-clinical staff were also well trained and many had or were working to accredited vocational qualifications in substance misuse. All staff we interviewed showed a high level of commitment to providing high quality service.

We found that the service placed a high emphasis on staff training. The service had invested heavily in training and support around continuing professional development for staff, and had funded four nurses to qualify as non-medical prescribers, 14 staff to complete NVQ 3 in health and social care, and 4 staff to complete NVQ Level 5 in Leadership and Management.

The level of expertise within the service enabled them to offer clinical placements to trainee doctors, nurses and social work students, and delivered training to stakeholders across the county. Clinical governance meeting minutes and data from the service reviewed as part of this inspection showed that in one quarter of the year the service had delivered 16 external training sessions to 122 participants; brief advice (alcohol), novel psycho-active substances (NPS), drug awareness, alcohol awareness, parental substance misuse and pharmacy training.

Staff received the necessary specialist training for their role, including drug awareness; assessment and recovery planning (including the use of ITEP (International Treatment Effectiveness Pilot; delivering MOPSI (models of psychosocial intervention) groups; harm reduction; blood borne virus screening using dry blood spot testing and needle exchange. The service also delivered specialist sessions in substance misuse and parenting, motivational interviewing, and modern-day slavery.

Substance misuse services

The service provided all staff with a comprehensive induction, and the training audits we reviewed showed all staff to have completed mandatory training. These audits informed training needs analysis by management to identify learning needs and provide further opportunities.

The organisation had robust recruitment and selection processes, including relevant pre-employment checks for all staff and subsequent disclosure and barring checks completed every four years.

All staff received regular supervision and yearly appraisal from appropriate professionals, confirmed through audit files reviewed by the inspection team. Staff we interviewed told us that supervision was consistent and very rarely cancelled. Staff received regular supervision and appraisal, which was audited quarterly by senior management.

Regular team meetings took place at each hub. The multidisciplinary team met once a week and complex case meetings occurred once every two weeks.

The organisation had effective processes for addressing concerns about staff performance, and managers told us that they felt well supported by central office when following these processes. Managers described circumstances where staff had not met their objectives and demonstrated the appropriate level of competency during their probation period and of this leading to termination of employment.

Managers had experience of making referrals to the disclosure and barring service (DBS) relating to unprofessional conduct after staff were dismissed, and had made referrals to the nursing and midwifery council (NMC), taking part in the subsequent investigation.

Volunteers we interviewed felt well supported and had received appropriate induction and training to perform their roles effectively. This included group training sessions that specifically addressed the challenges of transitioning from a client to a volunteer, with an emphasis of safe professional boundaries.

Multidisciplinary and interagency team work

The service demonstrated excellent interagency team work. The service developed pathways and models to ensure high quality care for clients with mental health problems through a well- developed dual diagnosis pathway. A formal protocol had been developed with the local mental health trust that was regularly reviewed and updated every year. The protocol included named dual diagnosis leads within the service hubs and key mental health services (in-patient wards, adult mental health teams, emergency duty psychiatric service and talking therapies) to promote collaborative working and continuity of care for clients.

From the city hub, the clinical psychologist had led on a number of initiatives to promote good interagency work. An AMHT assessment clinic was delivered monthly within the hub by the AMHT assessment team, with joint assessments by the AMHT psychiatrist. The service's clinical psychologist delivered a monthly clinic at a local mental health hospital to review dual diagnosis clients and provide enhanced engagement. Staff from the emergency duty and adult mental health teams spent time shadowing recovery workers at the service facilitating recovery support groups. Similar initiatives existed in the north and west of the county and the south of the county, with joint training events, attendance at team meetings and quarterly caseload reviews to identify mutual clients and joint planning of service delivery. In the south of the county the service attended a mental health liaison forum with a range of statutory and voluntary sector providers. The service had developed a bespoke information sharing form that enabled the service to give and receive feedback on clients' psychological wellbeing with their GP and the AMHT where appropriate, with their consent. This has led to GP reviews, referrals between services and advice from the AMHT for the management of clients from within the substance misuse service. This is in line with Public Health England's guidance, "Better care for people with co-occurring mental health and alcohol/drug use conditions" 2017.

The service was an active member of a county wide network of recovery services and contributed through the delivery of training to hospital staff, satellites and coordinated care pathways for clients in a mental health supported housing service. The service had also delivered training sessions to university staff and students around substance misuse and had awareness raising stalls at a university fresher's fair. Managers told us that the service was liaising with local army and navy representatives to agree referral pathways for service men and women with substance misuse needs, and have attended wellbeing events to raise awareness of the service.

The service worked closely with the local police to identify and support victims of modern slavery, as part of a

coordinated local initiative. Staff from the service attended a reception centre to identify victims known to the service and liaised with other agencies to assess support needs of people brought in. At least one person was directly engaged with the service at this stage, but local police stakeholders described the service as having provided considerable value to the long term safeguarding of victims in partnership with the police and other services. The service had also been involved in providing support for a number of individuals who had been victims of criminal exploitation and cuckooing (a form of crime in which drug dealers take over the home of a vulnerable person in order to use it as a base for drug dealing) across the county.

Care records showed that care coordinators were clearly identified, and all clients we spoke with know who their key-worker was.

The service held regular multidisciplinary team meetings attended by a range of clinical anon-clinical staff, where complex and high-risk cases were managed. These meetings were attended by senior clinicians

The service had effective protocols in place around care shared between the hub and client's GP practices and with pharmacies. A training programme for GPs and pharmacists was delivered by staff from the service at the city hub, and offered Royal College of General Practitioners accredited training in drugs and alcohol, motivational interviewing, and needle exchange.

The service produced a newsletter for GPs and pharmacists to keep them up to date with service developments, which we reviewed during this inspection. The newsletter included an offer for any interested doctors or pharmacists to shadow clinics at the service to enhance their understanding of substance misuse, and the offer of clinical advice from the service's consultant psychiatrist on matters relating to substance misuse.

Recovery plans included clear care pathways to other supporting services. Clients were supported to access residential detoxification and rehabilitation services through a well-defined pathway, although two stakeholders commented that this could be a lengthy process.

Good practice in applying the Mental Capacity Act

Staff understood their responsibilities in relation to the Mental Health Act 1983. Training and guidance on the MCA was provided by the consultant psychiatrist. We found evidence of considerations of capacity to consent being impaired by mental illness and / or intoxication in care records and clinical meeting minutes.

Listening to and learning from concerns and complaints

The service had received four formal complaints in the 12 months prior to the inspection. While no complaints had been fully upheld, some had subsections partially upheld from which learning had been taken. Managers told us that the majority of complaints raised were dealt with informally at local level. The service provided examples of changes made to the service and to individual care plans in response to complaints raised. Clients had raised the issue of BBV test results being delayed due to the need for them to be provided by the hepatology nurse. A revised BBV pathway enabled trained recovery workers to deliver the results, meaning that they were received within three weeks. We also found examples of nominated pharmacies and appointment times being adjusted to meet the request of individual clients in response to complaints.

Meeting the needs of all people who used the service

Staff demonstrated an understanding of the needs of vulnerable groups, in particular people with mental health problems and women experiencing domestic violence, for whom the service had specific protocols and pathways. The service delivered the Freedom Programme in-house for women in abusive relationships and had referral pathways to local domestic abuse services.

At the last inspection, we found that there was a lack of support designed for people from black and minority ethnic backgrounds and the lesbian, gay, bisexual and transgender community. The service had begun to address this through ensuring that the assessment process included gender identity and sexual orientation, and had made a commitment to work with a local LGBT+ organisation. However, a dedicated pathway and joint training arrangement was still in the planning stages.

Substance misuse services

Are substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Clients we spoke to said that staff are knowledgeable, understanding, supportive, encouraging and non-judgemental. They said that staff treat them with dignity and respect, and that they can speak to staff privately.

All staff we encountered spoke about clients with warmth and respect and positive regard. Clients told us that staff are always friendly and welcoming. During our visit we witnessed staff and managers greeting clients by name and taking a genuine interest in them.

Staff avoided the use stigmatising language and showed a high level of understanding and compassion for the causes and consequences of people's substance use. This was observed during informal observations whilst in the four hubs and also in the multi-disciplinary team meeting we observed at the Witney hub. We observed exclusively positive interactions between staff and clients, which was reflected in clients' feedback that all staff were friendly and welcoming. Staff fed back that they were well supported by managers and colleagues which enabled them to maintain good rapport with all clients. We reviewed the mandatory training record at the Oxford hub and this showed that all staff had completed training in equality and diversity. The service also carried out annual equality and diversity audits and had clear action plans in place to address any areas identified for improvement.

We observed staff responding calmly and confidently to clients experiencing distress while waiting to see a worker during a busy engagement clinic. The service had found that clients in the engagement stage of treatment who were still actively using substances found it very hard to manage fixed appointment times. The segmentation of the caseload and scheduling of weekly "sit and wait" clinics allowed clients at the engagement stage of treatment a longer timeslot with the relevant staff present to meet their needs. This had reduced the frustration and risk of disengagement for clients and decreased the pressure on the wider staff team. The service experienced a very low number of client related incidents at the city hub – one in 12 months, which the staff attributed in part to this approach.

Staff were able to access interpreters for clients whose first language was not English or for British Sign Language interpreters. Information in other languages was not freely available although this could be translated and printed out as needed. Posters were on display in reception areas which stated how clients could access information in various other languages.

Advocacy posters were on display, however some clients at the Banbury hub told us that they had to ask staff for advocacy information as it was not readily available.

At the end of each week at the city hub, clients successfully completing their treatment were invited to celebrate with staff and their peers by adding a symbol to a wall chart showing the running total of people completing successfully. The recovery lead also invited clients to share their messages of support and encouragement with other people in treatment through a message book. Clients at three hubs told us that they found hearing and seeing these sorts of messages motivating and supportive.

Involvement in care

Clients told us that they had been involved in their care planning and that staff helped them to think through different options to consider what would be best for them. There were suggestions boxes in the reception areas which clients used to post feedback forms. We reviewed the feedback forms from a one month period and most of these contained compliments about staff and the service provided. Where improvements had been suggested there were responses attached to these. Clients told us that they felt confident that any suggestions they made would be considered.

There was a monthly service user forum in place which was facilitated by the volunteer co-ordinator. The discussions covered topics including activities and therapies, environmental issues and community events. A member of staff also attended the monthly forum however one meeting was cancelled when they were unavailable.

Each hub produced a service user newsletter containing feedback and updates, and displayed "you said, we did" boards in client waiting areas. New initiatives had been

introduced in response to service user feedback, including a counselling satellite being delivered at the Banbury hub and free first aid training for service users. The service had plans to integrate their own service user group with the regional county service user forum.

The service delivered an accredited (Open College Network Level 2) peer mentoring programme across all hubs. Staff and clients told us that peer mentors added a great deal of value to service, in particular with their "meet and greet" role that helped clients feel more welcome and at ease when visiting the hub, offering the chance to get informal peer support from someone who could identify with their experience and role model successful recovery.

Clients told us that their family members had been involved in their care as requested. A specialist family support organisation delivered weekly sessions at the Witney hub. Staff were in the process of setting up a 'family, friends and concerned others' group to provide a forum for family members and friends to obtain support from peers.

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

Good

Access, waiting times and discharge

The service's acceptance and referral criteria was clearly displayed within waiting areas and on service literature, including the website. In practice staff told us that because of this it was rare to receive inappropriate referrals, and when this did occur it was for clients living in neighbouring counties where waiting times for opiate substitution therapy were understood to be longer.

The service had established a clinic timetable and process for gathering medication information that ensured minimal delay between referral, assessment and start of treatment. We saw examples of assessments, prescription starts and medical reviews taking place within 24 hours, and of waiting times for prescribing rarely exceeding seven days. We observed client at high risk or harm and hard to engage clients being able to re-enter treatment quickly. The clinic timetable also offered a choice of times for clients in the core caseload to attend, and evening appointments for clients in employment.

The service responded promptly to people being released from prison, offering initial assessment and bridging prescriptions as needed. This ensured that clients at highest risk of accidental overdose were kept safe. A dedicated engagement lead and clinic ensured that clients at greatest risk of harm and of dis-engagement from treatment were pro-actively engaged in treatment, BBV screening and provided with Naloxone training and kits. Engagement clinics were structured to avoid fixed appointment slots, which had been found to be hard to manage for clients still using substances. Whilst this meant that clients were required to sit and wait during a half-day clinic session, it had improved engagement and attendance through allowing greater flexibility around arrival times. Staff told us that this initiative had improved relationships between staff and clients, as people were very rarely turned away from the service due to lateness, and also relieved pressure on other clinic days as clients with the most complex presenting needs were seen by the same team in one appropriate session.

The service had alternative care pathways and referral systems in place for people whose needs could not be met by the service. Staff gave examples of signposting people to young people's services, homelessness and mental health organisations, and had good existing links with these services. We found that alternative treatment options were discussed if a client was not able to comply with specific treatment requirements, for example, increasing dosages of opioid substitution medication or changing from one type of medication to another.

The service had an agreed response time for accepting referrals, completing an assessment and starting treatment specified in their contract with the local authority, and consistently exceeded their targets. The provider offered evening and weekend services, to meet the needs of clients who were working or had other commitments like caring responsibilities. The service had safe and age-appropriate spaces for the children of service users, overseen by a safeguarding lead, ensuring that women in particular did not find childcare problems a barrier to attending their appointments.

Substance misuse services

A dedicated recovery clinic for clients who were close to treatment completion was scheduled at the end of the week, to offer additional motivational support in advance of the weekends and to limit contact with other clients who may still be actively using substances. Clients and peer mentors told us that this helped them to feel safe in the service. Clients and staff told us that the segmented approach to case management supported a sense of progress through the service as treatment goals were met, which aided motivation to change.

Staff communicated with clients via their preferred methods, for example, emails or text messages. The service operated regular satellite clinics and mobile engagement programs, as an adjunct to the four main hub offices.

Discharge and transfers of care

Recovery and risk management plans reflected the diverse needs of clients, with clear evidence of regular liaison with other services, in particular mental health.

Where client's care was being transferred to another provider, for example, the adult mental health team, staff ensured continuity of care by keeping the case open for an appropriate length of time and confirming the client was fully engaged.

The service was responsible for care coordination of clients leaving the area to attend residential treatment, and maintained routine contact with the residential service throughout their stay and upon their return when their care plan would again be led by the service, usually in the form of aftercare but sometimes back into the main service.

Staff actively planned for clients discharge from the service as part of the recovery care plan.

Facilities that promote comfort, dignity and privacy

The hub facilities had full disabled accessibility and a selection of rooms that were used for a wide variety of purposes, with an extensive selection of information on offer. All sites had adequate rooms to carry out planned and responsive one-to-one sessions in privacy and comfort.

All clients we spoke with said they found the hub locations welcoming and comfortable, however one carer fed back that having one entrance placed abstinent clients at risk through contact with people still using substances. Managers of the service fed back that where this was a concern appointment times could be and had been adjusted.

Clients engagement with the wider community

The service offered clients a wide range of activities to engage with the wider community. A peer led programme, "Growing our community", for the month following our visit, included painting a local soup kitchen, a litter pick, DIY at a family centre, and garden maintenance for a church. The service had recently held a coffee morning to raise money for a cancer charity. These activities offered clients volunteering experience and were well publicised in the local community, and were led by two full time peer mentor and volunteer coordinators.

The social enterprise café also provided an interface with the local community, and was specifically funded to enable offenders with substance misuse issues into employment. These activities were well publicised, and we reviewed positive local media coverage that raised awareness of the service for those who may need it and also served to challenge stigma about people with substance misuse problems.

Staff supported clients to maintain and improve their family relationships through individual care plans, and through parenting groups run for clients with children. The service did not have a carers forum, however managers told us that this was in planning stages at the time of the inspection.

Education and work activities were actively supported by staff for clients at the appropriate stage of their recovery. The service had three dedicated education, training and employment workers who were present in each hub two to three days per week. These staff delivered job club, CV writing and one-to-one employment support. Clients could also access specific courses to learn new skills, for example, customer service.

Meeting the needs of all people who use the service

The comprehensive assessment ensured that issues relating to protected characteristics under the equalities act were explored, and regular audits of equality and diversity matters were carried out for each hub. All services users were the subject of equalities monitoring through the equality and diversity audits.

Substance misuse services

The service demonstrated a commitment to meeting the needs of groups with protected characteristics in a number of ways. The service had good safeguarding partnerships and a joint working agreement with the young people's treatment provider, and links with Age UK for older service users that the service planned to build on. All hubs were fully accessible with wheelchair accessible toilets and a wide range of resources suitable for service users with disabilities. The service undertook a weekly satellite session at a local hospital for people with disabilities who would struggle to travel to the hubs but also offered home visits and begun forging links with the statutory learning disability service. For pregnant clients, the service worked in partnership with clients' GP's, maternity services and children social care, underpinned by a three way agreement covering information sharing and joint work.

The staff teams were assessed by the internal quality assurance review process as having a good level of black and minority ethnic representation among the staff team and the client group**.** Clients care plans actively included adjustments for religious beliefs such as Ramadan, and the service had undertaken sessions at the Oxford Council of Faiths working in partnership with local faith groups.

The service delivered weekly women's groups, contributed and referred to the multi-agency domestic violence panel, delivered the Freedom Programme (for women experiencing domestic abuse) and allowed clients to request a worker of their own gender wherever possible.

The service had developed specialist pathways for women, offenders, homeless clients and clients with a dual diagnosis. For example, the outreach lead accompanied street outreach staff on early morning outreach sessions and operated in-reach satellites in local homelessness services, and the service had committed resource to join a "one-stop-shop" for homeless people based in the city centre.

The service planned to undertake some black and minority ethnic specific outreach and engagement work, and develop pathways and a joint training programme to support lesbian, gay, bisexual and transgender clients, however these initiatives were still in planning stages at the time of our inspection.

Listening to and learning from concerns and complaints

The service had received four formal complaints in the 12 months prior to the inspection, none of which were upheld. Alongside complaints, the service had received 176 compliments, 78 suggestions and 19 concerns. Managers told us that the majority of complaints raised were dealt with informally at local level. The service provided examples of changes made to the service and to individual care plans in response to concerns raised. Clients had raised the issue of blood borne virus (BBV) test results being delayed due to the need for them to be provided by the hepatology nurse. A revised BBV pathway enabled trained recovery workers to deliver the results, meaning that they were received within three weeks. We also found examples of nominated pharmacies and appointment times being adjusted to meet the request of individual clients in response to complaints.

Are substance misuse services well-led?

Outstanding ☆

Leadership

The service had a clear leadership structure that incorporated senior clinical leadership from a consultant psychiatrist and operational leadership from a senior operations manager and deputy operations manager.

The senior operations manager had been in post since the start of the contract in 2015, and whilst there had been some turnover in the deputy and hub management team, a stable management team had been in place for the nine months prior to the inspection.

We found that leaders had the skills, knowledge and experience to perform their roles, with significant experience in managing community substance misuse services. We found clinical and non-clinical leaders within the service to have extensive knowledge and experience to perform in their roles and to have detailed understanding of the service they led.

Staff and clients commented that leaders were visible and accessible within the service and could be easily approached. We saw examples of managers "leading from the front", carrying out client case management with high risk cases or clients were particularly challenging to the service in order to support front line workers.

Substance misuse services

Vision and strategy

The parent organisation, Turning Point, is a large national provider of health and social care services for people with learning disabilities, metal health and substance misuse issues. The organisation had a 5-year corporate strategy that underpinned the delivery of the service. Staff knew and understood the vision and the values of the service and understood their own roles in achieving it. The organisation recognised success within the service, which had won an award for having the highest levels of performance in the organisation. Staff knew and understood the vision and the values of the team and understood their own roles in achieving it. Staff demonstrated a sense of ownership and pride in their own part of the service whilst clearly explaining how It fitted into the wider picture.

All staff had a job description and a clearly defined role, and felt able to contribute to discussions about the strategy for the service and future developments. Staff showed an awareness of resource limitations and how best to utilise the funds available, although several commented that the service was well resourced in relation to staffing and the availability of residential treatment.

Culture

All staff we interviewed spoke very highly of the culture within the service and the wider organisation, drawing comparisons with others they had worked within and describing it as the best. Staff described the approach to working with clients as person centred and of striking a good balance between harm reduction and achieving abstinence from substances. Staff were complimentary about the collective skill set of the staff team and the ability to learn from their peers.

Three staff described job satisfaction arising from leaders within the team supporting them to develop according to their own interests (for example, homelessness, and harm reduction), giving them lead roles accordingly and empowering them to drive improvements and new initiatives. Staff felt empowered to lead within their own areas of the service and initiate new ways of working.

Staff surveys monitored morale, and showed high levels of satisfaction across all domains. Staff gave examples of support given by their line managers and the senior leadership team to support them to manage the stresses of working in a busy service. All staff we spoke with felt respected, supported and valued.

Some staff felt that some of the contractual benefits offered to staff were less favourable than for other similar providers they knew of or had worked for, citing levels of holiday pay and a policy of paying sick pay only after three days absence. This was something that staff said they would like to change, however also stated that they understood business reasons for the policies around reducing short term sickness and being able to offer competitive prices when bidding for contracts.

The organisation provided an employee assistance programme and occupational health service to support staff wellbeing. All eligible staff had received an appraisal which included conversations about future career development.

The provider recognised success within the service, which had won an award for having the highest levels of performance in the organisation, and a staff celebration even within the service was planned in the month following our visit.

The service invested heavily in the learning and development of its staff, which benefitted clients through the maintenance of a stable, motivated and highly skilled staff team. The service had responded pro-actively to the national shortage of qualified nurses by recruiting nurses from different backgrounds and enabling them to specialise in substance misuse, and supporting nurses to gain prescribing qualifications.

Staff described supervision and appraisal as regular and supportive, with most front-line staff praising the level of support they received from their own line managers and others across the hubs who would be easy to reach and approachable if needed.

Several staff described how their career had progressed within the organisation as a result of opportunities to build experience as well as formal training and support to study for qualifications. We spoke with staff with lived experience of substance misuse treatment who had completed training to become peer mentors and then become paid staff members.

No staff reported having been bullied or harassed by colleagues or managers but were able to describe what courses of action were open to them should this occur, and said they would have confidence in the organisation to address it. The service had a whistleblowing policy which staff were aware of, with information clearly displayed. The teams seemed to work well together, with several staff commending the team work approach of their colleagues.

Governance

The provider had a comprehensive schedule of meetings, reporting systems and audits to ensure good governance of the service. There were systems and procedures to ensure that the service was safe and clean, that there were enough staff, that staff were trained and supervised, that clients were assessed and treated well, that the service adhered to the MCA, services were managed well, that discharges were planned, that incidents were reported, investigated and learnt from.

The organisational risk and assurance department carried out inspection compliance audits across all hubs, and the audit reports we reviewed showed actions were followed up and completed in a timely way.

At service level, managers carried out audits of each caseload, of medicines, safeguarding and equality and diversity, applying an intelligence based approach to case management. The governance systems ensured safe clinical practice, with staff and managers describing an open, reflective culture that responded constructively when things went wrong.

The service used an incident reporting system that automatically flagged which serious untoward incidents required escalation and external reporting, for example, to commissioners within public health, the CQC, safeguarding teams or the police.

The service held monthly medicines management meetings, quarterly meetings for all CQC registered managers, and senior clinical governance team support meetings. Externally, the service participated actively in county-wide forums including the controlled drugs local intelligence network, domestic homicide reviews and inquests.

The service held monthly morbidity and mortality meetings jointly with the local authority public health team to ensure transparency and to share learning from deaths of people known to the service.

The policies, procedures and protocols we reviewed as part of this inspection were all in date and had been reviewed. Most included an equality impact assessment that showed the provider had considered potential unintended consequences for groups with protected characteristics under the Equality Act 2010.

We reviewed minutes of team and clinical governance meetings and found well-structured agendas and terms of reference that ensured that essential information was shared and discussed. This included learning from incidents, the development of new pathway models, joint work with external agencies and complaints. Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts.

The service placed a high emphasis on the importance of working collaboratively with a wide range of partners, providing lead staff members and investing time and resource in building safe, innovative pathway models which led to good outcomes. The dual diagnosis pathway, the integrated offender treatment pathway and the blood borne virus pathway had all been developed in partnership with stakeholders and addressed previously unmet need among the client population.

Management of risk, issues and performance

There was a clear quality assurance management and performance frameworks in place that are integrated across all organisational policies and procedures. We reviewed the organisation's corporate risk register, which clearly included the identification and proactive management of service level risk and was reviewed quarterly by senior management.

The service had robust business continuity plans in the event of adverse weather or other major disruption to service delivery. These had been successfully activated through an instance of IT systems failure affecting one hub and bad weather preventing staff travelling to work at three hubs. On both occasions disruption to client's treatment had been managed safely, with no interrupting to prescribing.

Sickness and absence rates were closely monitored by the organisation, with low levels of both being achieved by the service.

The service had not needed to make cost efficiency savings, and had successfully agreed for funding levels for specific areas be maintained, for example, residential treatment and in-patient detox. The management of the service described the service as well resourced, and attributed this in part to the service's ability to provide quantitative evidence of t's effectiveness through its activity and outcome data. The service had successfully funded specific projects from outside its core contract, for example, the social enterprise café received funding from the police and crime commissioner specifically to support ex -offenders to gain employment. The service had also been awarded funding to work with rough sleepers for a forthcoming partnership initiative.

Information management

The service used an electronic case management system that allowed data to be collected for case management audits, contractual performance reports and the national drug treatment monitoring system to be collected in ways that were not over-burdensome for frontline staff.

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 service had identified that a very high volume of calls were made to the Oxford hub and planned to make improvements to the telephone system to reduce the number that were missed. One stakeholder highlighted this issue, attributing it to the busy nature of the service and high demand, and emphasised that although staff could not always be reached on the telephone they still responded in good time.

Information governance systems included confidentiality of client records, and all systems were password protected with each user having their own log-in details and access permissions appropriate to their role.

Team managers had access to information to support them with their management role, enabling them to run bespoke performance reports and reports relating to staffing and client caseloads. Information was in an accessible format, and was timely, accurate and identified areas for improvement.

The service had developed information-sharing processes and joint-working arrangements with other services, including being entrusted with highly sensitive information shared by the local police and community safety teams. Confidentiality policies were clearly displayed and agreements signed and stored in all care records we reviewed.

Engagement

Staff, clients and carers had access to up-to-date information through regular newsletters, the service website and displays within the service and service user involvement forums provided access to senior managers within the service.

The management of the service were active members of local strategic forums, including CDLIN (controlled drugs local intelligence network), MASH (multi agency safeguarding hub) steering board, community safety partnership, domestic violence steering group, homelessness partnership, AMHT (adult mental health) locality meetings and police led steering groups. Management worked in partnership with public health commissioners to assess local needs around substance misuse and to develop the service in response to this. A stakeholder engagement event was planned for the month following our visit.

The service was actively engaged in the local community, delivering training and awareness raising events to a number of local groups, especially from the city hub. Alcohol awareness training for older people in supported accommodation, wellbeing events for students and older people, and outreach sessions with the East Timor community were organised in partnership with local community groups, helping to embed the service in the community, promote across to different populations. The service also engaged positively with the local press to publicise community engagement activities carried out by clients, all of which helped to challenge stigma around substance misuse and maintain a positive profile of the service and its value to the community.

Learning, continuous improvement and innovation

The organisation encouraged creativity and innovation to ensure up to date evidence based practice is implemented and imbedded. The segmented approach to managing the opioid substitution therapy clinics, the blood borne virus pathway, the dual diagnosis pathway and integrated

offender treatment model were all very successful examples of safe innovation meeting the particular needs of the client group. New innovations were well planned and managed with stakeholders and enjoyed significant commitment from front line staff who were empowered to lead and develop beyond their basic job descriptions.

Outstanding practice and areas for improvement

Outstanding practice

Start here...

Areas for improvement

Action the provider MUST take to improve

Start here...

Action the provider SHOULD take to improve

Start here...

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.

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.