Turning Point

Turning Point -Wakefield Inspiring Recovery Integrated Substance Misuse

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

We rated this location as good because:

- The service provided safe care. The care environment at all the premises was safe and generally clean. Staff told us that their caseloads were not too high to prevent them from working safely. Records included comprehensive risk assessments and staff managed risks well. Medicines were managed safely, including controlled drugs. Staff understood their responsibilities for safeguarding children and adults from abuse and neglect and complied with local safeguarding procedures.
- People received effective care which was informed by a comprehensive assessment of their physical and mental health needs. The service provided holistic support to individuals, taking into account their needs and social circumstances. We saw examples of innovative practice which was benefiting people using the service. Staff engaged in clinical audit and compliance with relevant national guidance was promoted.
- Clients and their relatives told us that staff treated them with respect and compassion. Recovery plans were developed in partnership with people using the service and the people we spoke with were happy with the information they were given about the support available to them and said they had choices. Clinics ran on time and people said their appointments were never cancelled. We observed positive and caring interactions between staff and clients.
- The service was accessible. At the time of our inspection there was no waiting list for the service and people were seen promptly for assessment and treatment following their initial referral. The provider engaged in outreach work and partnership working to target harder to reach populations. The premises were physically accessible to people with impaired mobility and the provider made arrangements to meet the communication and support needs of people with protected characteristics.
- Governance processes were well-embedded and enabled managers to monitor risks, outcomes for people using the service and staff performance. The service worked effectively in partnership with other stakeholder organisations, for example mental health and criminal justice services.

However:

- At the time of our inspection the service was in the process of changing cleaning providers and we identified some isolated infection prevention and control issues with the environment at Radcliffe House as a result of this.
- Some staff told us that they were experiencing work-related stress due to high caseloads and having to cover for vacant positions.
- Staff turnover had been high in the 12 months preceding our inspection which risked compromising the quality of care if staff were frequently changing.
- Some staff told us it was a challenge to complete mandatory training due to their high workloads and some e-learning modules were below 80% completion according to the provider's training figures.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community-based substance misuse services	Good 	See summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to Turning Point -Wakefield Inspiring Recovery Integrated Substance Misuse

Turning Point – Wakefield Inspiring Recovery Integrated Substance Misuse is part of a national charity called Turning Point. It is a community-based organisation offering treatment and support to people with drug and alcohol problems. It provides services from the following sites in Wakefield and the surrounding areas:

- Radcliffe House – Inspiring Recovery (service for adults aged 25 and over) in central Wakefield
- Cross Street – Inspiring Futures (service for young people aged up to 25) in central Wakefield
- Socialicious – a community café where clients of the service can work and gain vocational training, which also has space for training and group sessions
- Get Connected and Out There Everywhere – aftercare services providing psychosocial support in the community supported by a team of trained volunteer peer mentors
- Wesley Street – service for adults aged 25 and over in Castleford

The service provides medication assisted treatment, advice and information, group work, psychosocial interventions, harm reduction interventions, blood borne virus testing and immunisation. The service is delivered in partnership with other health and social care stakeholders through shared care arrangements. These include GP partnerships, the police, the probation service and a neighbouring NHS mental health trust.

This service was registered by CQC at its current location in August 2020 to provide one regulated activity: Treatment of Disease, Disorder and Injury. There was a registered manager in post at the service. This was the first time we have inspected the service since it was registered.

What people who use the service say

We spoke to nine clients in total. People using the service told us that they felt welcomed by staff and they were treated with respect and compassion. People said the premises were usually clean and they felt safe when attending their appointments. Clients spoke positively about the Buvidal opiate substitution treatment pilot the service was running at the time of our inspection and those receiving this treatment said it was greatly benefiting their recovery and overall wellbeing. People said their clinic appointments and group sessions ran on time and were never cancelled and they were happy with the level of information they were given about their medicines and recovery plans. Some people told us they were being supported to train as peer mentors, which was also beneficial to their recovery. People also told us how the service had supported them in other areas of their lives, for example accessing suitable housing and support following domestic abuse.

How we carried out this inspection

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

- toured the facilities at Radcliffe House, Cross Street, Socialicious and Wesley Street and looked at the quality of the environment
- observed how staff were caring for clients
- reviewed the management of medicines

Summary of this inspection

- spoke with nine clients and two relatives
- spoke with the registered manager, the clinical service manager/clinical lead support and the quality lead for the service
- spoke with 17 other staff members including nurse prescribers, team leaders, recovery workers, support workers, criminal justice workers, family workers and volunteer peer mentors
- attended and observed a group session with clients and a peer mentors' training session
- attended and observed a morning communication meeting and a daily prescribers' meeting
- looked at eight care and treatment records of clients
- received feedback from the lead commissioner for the service; and
- looked at a range of policies, procedures and other documents relating to the running of the service

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

Outstanding practice

We found the following outstanding practice:

- At the time of our inspection the service was running a pilot of a new prolonged release opiate substitution treatment. We observed a clinic and spoke to some of the people using the service, who spoke very positively about how this treatment was benefiting them and progressing their recovery from dependent substance use. The service was monitoring the outcomes from this pilot which were very promising, with minimal continued use of opiates by clients in the cohort. As a result of this, plans were being developed to increase the provision of this medicine within the service and the provider had begun the process of applying for a Home Office licence to hold stocks of the drug to increase its availability and bring more suitable clients into the programme.

Areas for improvement

Action the service SHOULD take to improve:

- The service should ensure that they continue to take action to reduce staff turnover and to fill the remaining vacancies, to provide consistency for people using the service and reduce the workload pressures on staff.
- The service should ensure that staff who are not up to date with their mandatory e-learning are supported to complete their outstanding modules as soon as possible.
- The service should ensure that they embed new arrangements for cleaning the premises as quickly as possible and continue to monitor the cleanliness of all areas of the premises through cleaning audits and environmental checks.
- The service should consider auditing how they apply the Mental Capacity Act so they are able to identify and act when they need to make changes to improve.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Community-based substance misuse services

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

Are Community-based substance misuse services safe?

Good

Safe and clean environment

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

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. Specific templates were used to document the assessments, for example in relation to fire risk, medicines storage and infection prevention and control. Staff completed relevant risk assessments prior to new services opening and reviewed them at least annually.

All interview and clinic rooms had alarms and staff available to respond. Due to the design of the internal doors at Radcliffe House and Wesley Street it was possible for a staff member to be trapped in a room if someone using the service became aggressive. This risk had been identified by the provider in the building risk assessment and mitigating procedures were in place, including guidance for staff on safe working and the provision of alternative meeting venues when significant risks were identified for specific people using the service. All the staff and service users we spoke to said they felt safe at both services.

All clinic rooms had the necessary equipment for clients to have thorough physical examinations. This included weighing scales, blood pressure monitors, ECG machines and pulse oximeters, and at least one of the clinic rooms at each service also had an examination couch.

Most areas were clean, well maintained, well-furnished and fit for purpose. We identified some isolated cleanliness and hygiene issues including an overflowing clinical waste bin, a hand wash sink with a stained overflow outlet and incorrectly stored cleaning equipment. The registered manager explained these shortfalls were likely to have arisen because they were in the process of changing over to a new cleaning company, which had been required unexpectedly shortly prior to our inspection. The issues we identified were resolved on the day of inspection and people using the service told us that the premises were usually clean and they had no concerns about the care environment.

Staff made sure cleaning records were up-to-date. Cleaning equipment was colour coded to prevent cross-contamination between different areas of the premises. We saw records of daily, weekly and monthly

environmental checks carried out by staff at Radcliffe House and staff said the cleaners also completed daily records of cleaning. Staff were not able to locate the up to date cleaning records during the inspection due to the change of cleaning providers but the cleaning specification for the new cleaners and the template record they will complete were reviewed. We also saw completed daily cleaning records for the clinical areas, which were completed by staff and up to date.

Staff followed infection control guidelines, including handwashing. We observed staff washing their hands and using alcohol gel and we saw the reports from infection prevention and control audits carried out in February 2022 and July 2021 which included a review of staff compliance with the provider's infection and prevention and control policy and relevant national guidance. We observed staff using personal protective equipment such as face masks and disposable gloves correctly to minimise transmission of infections within the service.

Staff made sure equipment was well maintained, clean and in working order. We did not observe any broken or dirty equipment during the inspection. There was a checklist for documenting the cleaning of the clinic rooms by staff. These were complete up to the date of inspection and stated that the equipment in each room had been cleaned daily.

Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep clients safe. Recovery workers told us that they had large caseloads but they all felt that they could work safely with the number of clients they had. Staff also told us they had capacity to follow up with people proactively if they missed appointments or had not been in touch for a while. People using the service told us that they did not have appointments cancelled due to staff shortages and they could usually get hold of their recovery worker if they needed to speak to them.

The service had a reasonably low vacancy rate. At the time of our inspection the service had 96.6 WTE staff and 17 vacant posts (of which five were due to an increase in funding leading to the creation of additional roles within the service). All vacant posts had been advertised at the time of our inspection and the manager was using a spreadsheet recruitment tracker to monitor progress towards filling the remaining vacancies. Staff told us that the vacancies within the service were causing their workloads to be high which sometimes caused stress, but several staff members also commented that they believed this was improving and they were confident the service would be fully staffed soon.

The service had a low rate of agency staff usage. In the three months prior to our inspection the rate of agency staff as a percentage of total staff at the service was between 1% and 5%. People using the service told us that they did not experience frequent changes of key worker.

Managers made arrangements to cover staff sickness and absence. The registered manager told us that staff were often able to cover for short term absence within the teams and they used agency staff to cover any longer term absence.

Managers limited their use of bank and agency staff and requested staff familiar with the service. We spoke with an agency nurse who told us that she had been working at the service for several months.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. The registered manager told us that agency staff had an interview and were required to complete the same mandatory e-learning as substantive staff prior to working at the service. The agency nurse we spoke with told us that she had received a comprehensive induction.

The service's staff turnover rate in the 12 months preceding our inspection was high at 48%. However, due to an increase in funding there had been 68 new staff joining the service and 35 leavers during this period. The provider had been implementing measures to reduce the number of staff leaving including retention interviews with any staff member submitting their resignation. The monthly rate of turnover had been reducing since December 2021.

Managers supported staff who needed time off for ill health. Staff told us they felt well supported by the provider in relation to their wellbeing and occupational health.

Sickness levels were low and significantly reducing following the impact of the COVID-19 pandemic. As of February 2022 there were 4% of staff absent from the service due to sickness. Of these the majority were short-term absences with only 2% of total staff on long-term sickness absence at the time of our inspection.

Managers did not use a recognised tool to calculate safe staffing levels. The senior operations manager was responsible for calculating the number of staff needed based on the value of their commissioning contracts and the needs of people using the service. Staff and people using the service all told us that they felt there were sufficient staff at the service to provide safe care, although some staff said that their work was stressful due to the vacancies, which had resulted in higher caseloads.

Medical staff

The service had enough medical staff. The staffing model has a clinical lead who is a specialist doctor in addictions psychiatry, a further specialist doctor and a range of non-medical prescribers including the clinical service manager/ clinical lead support who is a nurse prescriber and a dual diagnosis nurse consultant who works in a partnership role with the service from the Mental Health Trust. Support and recovery workers told us that their senior medical and nursing colleagues were accessible and supportive, helping them to provide a holistic service to their clients. In particular, the shared nurse consultant role was a valuable resource when staff needed additional support in working with clients with significant mental health needs.

Mandatory training

Staff had completed and kept up-to-date with most of their mandatory training. Online mandatory training had an overall completion rate of 94% at the date of our inspection, with individual courses all at 90% or higher with the exception of information security (75%), risk assessment (72%) and safeguarding level 2 (67%, although 100% of staff had completed level 1 safeguarding training). Some staff told us that they did not always feel they had time to complete e-learning due to their high caseloads and the resulting demands of their client work.

The mandatory training programme was comprehensive and met the needs of clients and staff. Staff completed a range of e-learning modules including safeguarding, infection prevention and control, first aid and conflict management, as well as service-specific modules such as drug and alcohol awareness and harm reduction.

Managers monitored mandatory training and alerted staff when they needed to update their training. We saw evidence on staff files that mandatory training compliance was reviewed with staff during their monthly supervision meetings. Staff told us that they received a reminder alert if any of their mandatory training modules needed to be refreshed.

Assessing and managing risk to clients and staff

Staff assessed and managed risks to clients and themselves well. They responded promptly to sudden deterioration in clients' physical and mental health. Staff made clients aware of harm minimisation and the risks of continued substance misuse. Safety planning was an integral part of recovery plans.

Assessment of client risk

Staff completed risk assessments for each client on admission to the service, using a standardised assessment tool, and reviewed this regularly, including after any incident. There were up to date risk assessments on all the records we reviewed.

Staff used recognised risk assessment tools in working with clients, such as the severity of alcohol dependence questionnaire (SADQ) and used these to inform the individual's plan of care.

Staff could recognise when to develop and use crisis plans according to client need. The risk assessment tool included the risk of self-harm and suicide and we saw evidence on the records that safety plans were developed with clients where these risks were identified.

Management of client risk

Staff responded promptly to any sudden deterioration in a client's health. Staff described how they used their professional curiosity and followed up any client who they felt was disengaging from the service. The service offered outreach and harm reduction services which aimed to reach as many potential service users as possible and support them to access the service to work towards recovery or less harmful substance use.

Staff followed clear personal safety protocols, including for lone working. All the clinic and interview rooms where staff would be alone with people using the service had emergency alarms which staff could operate to call for assistance. Most of the staff we spoke to were familiar with the service's lone working policy and told us that they felt safe at work. Most of the clients we spoke to told us they had never experienced any aggression from peers while using the service. The minority who had told us that the staff had handled this well and helped them to feel safe.

Safeguarding

Staff understood how to protect clients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. All staff were up to date with their mandatory Level 1 safeguarding training. An additional 32 staff members (67%) had completed a Level 2 safeguarding workshop and the registered manager told us that they were planning to introduce Level 3 training for senior staff.

Staff could give examples of how to protect clients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff received equality and diversity training as part of their mandatory training and 100% of staff were up to date with this.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff told us that they received additional training which supported them in this, for example domestic violence awareness. Staff could give examples of how they worked with other agencies to ensure people were safeguarded from abuse, for example through participation in local multi-agency risk assessment conferences**.**

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All the staff we spoke with about safeguarding, including agency staff and volunteers, knew how to identify signs of abuse and were familiar with the service's procedure for reporting safeguarding concerns.

Managers took part in serious case reviews and made changes based on the outcomes. Lessons learned from safeguarding referrals were shared within the service and also more widely within the provider organisation.

Staff access to essential information

Staff kept detailed records of clients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Client notes were comprehensive and all staff could access them easily. Notes were stored electronically and staff told us that they found the system easy to use. Staff received training on using the system as part of their mandatory training and 98% of staff were up to date with this. All the client records we reviewed included comprehensive information about the individual's needs and the plans for their clinical care and psychosocial support.

When clients transferred to a new team, there were no delays in staff accessing their records. All staff had access to the same records system, so when clients moved on to aftercare support the staff in their new team could access their records instantly. The provider had a clear policy on transfers of care from the young people's service to the adult teams and staff were aware of this.

Records were stored securely. Electronic records were password protected and staff locked their terminals before leaving them unattended.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each client's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. We observed a buprenorphine clinic and saw that staff handled controlled drugs safely and in accordance with legal requirements.

Staff reviewed each client's medicines regularly and provided advice to clients and carers about their medicines. People using the service told us that they received regular reviews of their prescribed medicines and they had been given information about their medicines which they were able to understand.

Staff completed medicines records accurately and kept them up-to-date. All the records we reviewed included accurate and up to date information about the person's prescribed medicines and records were kept in relation to controlled drugs in accordance with the additional legal requirements which apply to these medicines.

Staff stored and managed all medicines and prescribing documents safely. Controlled drugs were stored securely and safeguards were in place to ensure the safe management of these medicines, which carry the risk of diversion and abuse. The only other medicines on site were vaccines and emergency medicines. Vaccines were stored at the correct temperature, which was regularly checked by staff.

Emergency medicines (to treat anaphylaxis and opioid overdose) were stored within a grab bag in the clinical area and were all within their expiration dates. All staff we spoke with could tell us where the emergency medicines were. The service did not have emergency oxygen on site, however we saw evidence that this had been risk assessed against relevant guidelines from the Resuscitation Council UK and this risk assessment was reviewed when changes were made to the clinical care provided (for example following the commencement of on-site administration of opiate substitution treatment). Staff told us that they had received first aid training and they knew what the service's policy was if someone needed emergency medical attention.

Staff learned from safety alerts and incidents to improve practice. We observed a morning staff meeting at which a national alert about diamorphine shortage was shared and the potential impact of this on the service was discussed with the staff team.

Staff reviewed the effects of each client's medicines on their physical health according to NICE guidance. People using the service received ongoing monitoring of their physical health including blood pressure monitoring, pulse oximetry and electrocardiographs as required.

Track record on safety

The service had a good track record on safety.

All deaths of people using the service were reviewed through the provider's mortality and morbidity meetings, to ensure that any lessons to be learned could be identified and used to effect ongoing improvements to the service. The provider benchmarked the service against its other community substance misuse services and this location had not been identified as an outlier in terms of adverse events or client mortality.

Reporting incidents and learning from when things go wrong

The service managed client safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave clients honest information and suitable support.

Staff knew what incidents to report and how to report them. The service used the Datix incident reporting system and staff told us they knew how to use it.

Staff raised concerns and reported incidents and near misses in line with the service's policy. Staff told us that they felt comfortable reporting incidents when things went wrong and said there was no culture of blame at the service. We reviewed incident records and saw that staff had clearly documented what had happened, the steps taken to investigate the incident and any lessons learned.

Good

Community-based substance misuse services

Staff understood the duty of candour. They were open and transparent and gave clients and families a full explanation if and when things went wrong. Staff received mandatory training on handling incidents, including the duty to share information with people affected by untoward incidents in some circumstances.

Managers debriefed and supported staff after serious incidents. Some of the staff we spoke with had reported an incident previously and they told us they had felt well supported.

Managers investigated incidents thoroughly. Clients and their families were involved in these investigations. The incident records showed that incidents were investigated fully and everyone affected was involved in the investigation.

Staff received feedback from investigation of incidents, both internal and external to the service. We saw evidence in the staff meeting minutes that lessons learned from incidents were shared and discussed with staff. For example, record keeping issues identified from mortality and morbidity reviews were disseminated to all staff teams through their local meetings and kept under ongoing review through the service's records audits.

Are Community-based substance misuse services effective?

Good

Assessment of needs and planning of care

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

Staff completed a comprehensive psychosocial assessment of each client. All the records we reviewed included a detailed assessment of needs which were relevant to their recovery from addiction, including their social circumstances. Staff told us that the system had recently changed so that a triage team completed the initial assessment of new clients, but staff who acted as key workers could all explain how they reviewed the initial assessment with their clients to ensure they had a good understanding of their needs.

Staff made sure that clients had a full physical health assessment and knew about any physical health problems, both related to their substance use and otherwise. People using the service told us that their physical health needs were taken into account and care records included assessments of clients' physical health. We observed a buprenorphine clinic at which physical observations were taken prior to administration of the opiate substitution treatment.

Staff developed a comprehensive care plan for each client that met their mental and physical health needs. All the records we reviewed included a detailed recovery plan for the individual which covered physical health and psychosocial needs.

Staff regularly reviewed and updated care plans when clients' needs changed. The records we reviewed showed evidence of recovery plans being reviewed and staff told us that they regularly reviewed these plans as needed by each client.

Good

Community-based substance misuse services

Care plans were personalised, holistic and recovery-orientated. All the recovery plans we reviewed included the client's views and a range of information about their substance use, other psychosocial needs and personal strengths and goals. People using the service told us that they felt listened to by staff and could contribute to their recovery plan in a meaningful way.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the client group and consistent with national guidance on best practice. They ensured that clients had good access to physical healthcare and supported clients to live healthier lives.

Staff provided a range of care and treatment suitable for the clients in the service. All the records we reviewed showed that all clients, including those on a clinical treatment pathway, were also offered psychosocial interventions and support. People using the service told us that they had benefitted from this holistic support, for example in relation to their mental health or social circumstances, in addition to receiving clinical treatment for their substance use.

Staff delivered care in line with best practice and national guidance (from relevant bodies such as NICE). The service delivered care under a range of treatment pathways for different needs, which were in line with relevant national guidance on addiction recovery from NICE and Public Health England. Staff received training as required by their roles on the relevant national standards and the treatment pathways used within the service. Relevant NICE guidance was referred to during the multidisciplinary team meeting we observed. We also saw that clinical staff had access to prescribing guidelines within the clinic rooms.

Staff made sure clients had support for their physical health needs, either from their GP or community services. We saw evidence on the records we reviewed that the service shared information with clients' GPs appropriately and the nurses we spoke with confirmed that clients' GPs were kept updated about any changes to their medicines prescribed by the service.

Staff supported clients to live healthier lives by supporting them to take part in programmes or giving advice. People using the service told us that they received support from staff about healthy living. The service ran additional groups to support people with their lifestyle more widely, for example smoking cessation. There were posts for two wellbeing nurses within the service but these were vacant at the time of our inspection. We saw that the provider was actively trying to recruit to these roles.

Staff used recognised rating scales to assess and record severity and outcomes. The records we reviewed showed evidence of evidence based scales relating to substance use, such as the alcohol use disorders identification test (AUDIT), which were embedded within the care pathways used by the service. The national early warning score (NEWS) scale was used if any concerns about sepsis were identified from a client's presenting symptoms.

Staff used technology to support clients. During the COVID-19 pandemic the service shifted to providing many of their group sessions online using videoconferencing. This was continuing at the time of the inspection. We observed an online group facilitated by recovery workers and a peer mentor which was well run and received positively by the people attending.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The nurses we spoke to confirmed they had time to engage in clinical audit in line with the provider's policy. The service had a comprehensive audit calendar which included a range of clinical audits. The findings from audits were discussed in team meetings for learning to be fed back to the wider staff team. The senior managers also attended regional meetings, where learning from local audits could be shared and benchmarked across the wider organisation.

Managers used results from audits to make improvements. The reports from sample audits we reviewed included action plans which were reviewed at governance meetings to ensure improvements were implemented as needed.

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of each client. The service had entered into a partnership working agreement with a neighbouring NHS mental health trust to provide integrated support for people's mental health needs for both adults and young people. Staff told us that they valued the support this offered them when working with people with significant mental health needs.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the clients in their care, including bank and agency staff. The staff files we reviewed included evidence of relevant qualifications and previous employment history and the registered manager confirmed that agency staff had an interview prior to commencing work at the service.

Managers gave each new member of staff a full induction to the service before they started work. All the staff we spoke with, including an agency staff member and a peer mentor, confirmed that they had received a comprehensive induction relevant to their role within the service.

Managers supported staff through regular, constructive appraisals of their work. The provider monitored completion of annual appraisals and at the time of our inspection 97% of eligible staff had completed an appraisal during the previous 12 months.

Managers supported staff through regular, constructive clinical supervision of their work. The provider monitored completion of monthly one to one supervision meetings which covered managerial and casework supervision. At the date of our inspection 93% of staff were up to date in accordance with the provider's supervision policy. Where staff members had not attended a supervision meeting within the last month there were good reasons for this.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. Teams attended morning briefing meetings and we had the opportunity to observe one of these at which a range of relevant information was shared. Monthly team meetings also took place for the different teams and minutes of these meetings were taken and shared with those who could not attend.

Managers identified any training needs their staff had and gave them the opportunity to develop their skills and knowledge. We saw evidence on the staff files of how training needs were identified through staff supervision and appraisal. However, some staff told us that it was a challenge to keep up to date with their training due to their high caseloads of clients.

Managers made sure staff received any specialist training required for their role. Staff had the opportunity to access a range of specialist training relevant to their role, for example motivational interviewing, group facilitation skills and mindfulness based relapse prevention. Staff told us that they had received enough training to support them in delivering specialist care within their team.

Managers recognised poor performance, could identify the reasons and dealt with these. We saw evidence on the staff files of how managers worked with staff to improve performance through a documented improvement plan. The registered manager explained they would receive support from Turning Point's national HR team in the event that performance issues progressed to disciplinary action.

Managers recruited, trained and supported volunteer peer mentors to work with clients in the service. We had the opportunity to observe a peer mentor training session which was part of a series of sessions providing induction and training relevant to the role. We also spoke with a peer mentor who told us that they felt well supported by the organisation and were able to use and develop their individual skills as a volunteer.

Multidisciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit clients. They supported each other to make sure clients had no gaps in their care. The team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss clients and improve their care. A weekly clinical review meeting was held which was attended by a multidisciplinary team of staff. We observed one of these meetings at which general information was shared, for example relating to national alerts, and specific cases were discussed. In addition, the multidisciplinary team held fortnightly complex case review meetings, to which any member of staff could bring a challenging case for advice and support from the clinical team. Minutes of these meetings showed that they were taking place regularly.

Staff made sure they shared clear information about clients and any changes to their care, including during transfers of care. We saw evidence on the notes that information about prescribed medicines was obtained from GPs for all new clients and that information was shared with GPs and other relevant stakeholders, such as social services and criminal justice teams as needed.

Staff had effective working relationships with other teams in the organisation. The separate teams within the service shared information effectively, for example when clients moved from the young people's service to the adult service or when someone moved on to be supported by the aftercare team. People using the service told us that they were kept informed throughout their journey with the service.

Staff had effective working relationships with external teams and organisations. The partnership working agreement with a neighbouring NHS mental health trust was functioning effectively and providing good support to staff when working with people with significant mental health needs. We also saw evidence of positive partnership working with the police, the probation service and other criminal justice organisations for clients on the criminal justice care pathway.

Good

Community-based substance misuse services

Some staff told us that the partnership working with GPs to provide shared care was variable, working well with some practices and less well with others. The provider had identified this as an issue with some practices and was actively working to improve the shared care arrangements with these practices.

The lead commissioners for the service told us that they worked effectively with the management team and they were confident that people using the service were receiving a good standard of care. The provider involved commissioners in a range of aspects of the service including governance meetings, mortality and morbidity reviews and staff recruitment.

Good practice in applying the Mental Capacity Act

Staff supported clients to make decisions on their care for themselves. They understood the service's policy on the Mental Capacity Act 2015 and knew what to do if a client's capacity to make decisions about their care might be impaired.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. The provider's training compliance data stated that 100% of staff were up to date with their Mental Capacity Act e-learning. Staff were able to briefly explain how the Act applied to their work.

Staff gave clients all possible support to make specific decisions for themselves before deciding a client did not have the capacity to do so. People using the service told us that they were given information about their options for care and treatment in formats they were able to understand and they were given time to consider the information before making choices.

Staff assessed and recorded capacity to consent clearly each time a client needed to make an important decision. All the records we reviewed included a documented assessment of the individual's capacity to consent to their treatment and a record that consent had been given. People using the service told us that staff sought their consent before providing treatment.

When staff assessed clients as not having capacity, they made decisions in the best interests of clients and considered the client's wishes, feelings, culture and history. Staff were able to give us examples of when capacity assessments had identified that an individual did not have the capacity to make a particular decision about their care and they could describe how care was provided in people's best interests in those circumstances, taking into account the views of the individual and their family members where appropriate.

The service did not monitor how well it followed the Mental Capacity Act other than ad hoc reviews through complex case review and multi-disciplinary team meetings. However, we did not identify any concerns about compliance with the Act through our review of client records or discussions with staff and clients.

Are Community-based substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff treated clients with compassion and kindness. They understood the individual needs of clients and supported clients to understand and manage their care and treatment.

Good

Community-based substance misuse services

Staff were discreet, respectful, and responsive when caring for clients. We observed staff engaging with clients in positive and supportive ways throughout our inspection. People using the service and family members told us that staff were always respectful and maintained their confidentiality.

Staff gave clients help, emotional support and advice when they needed it. People using the service spoke highly of the holistic support they received from their key workers. They also told us that staff were available when they needed them.

Staff supported clients to understand and manage their own care treatment or condition. Staff told us how they worked with clients to empower them to work towards their recovery from addiction. People using the service told us that they were given information about their care plans and any medicines they were prescribed.

Staff directed clients to other services and supported them to access those services if they needed help. Clients we spoke with told us that they had been supported by their key worker to access other services, for example mental health and housing, which had helped them to turn their lives around.

Clients said staff treated them well and behaved kindly. Without exception all the clients we spoke with told us that staff were caring and supportive, an example comment was “nothing is too much for my keyworker, they go above and beyond”.

Staff understood and respected the individual needs of each client. People using the service told us that staff treated them as individuals and understood their needs and recovery goals.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards clients and staff. The service had a whistleblowing procedure and all the staff we spoke with knew how to raise a whistleblowing concern and said they would feel comfortable doing so if necessary.

Staff followed policy to keep client information confidential. All staff, including agency workers, received mandatory training on confidentiality and safe handling of information as part of their induction.

Involvement in care

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

Involvement of clients

Staff involved clients and gave them access to their care plans. The records showed that clients had been given copies of their care plans and the plans themselves included clients’ own views, preferences and goals. All the people we spoke with confirmed that they had been offered a copy of their recovery plan.

Staff made sure clients understood their care and treatment (and found ways to communicate with clients who had communication difficulties). People told us that they had been given information, including written information, about the service in formats they could understand. The registered manager told us that staff had access to interpreting services if they were supporting someone who did not speak English fluently.

Good

Community-based substance misuse services

Staff involved clients in decisions about the service, when appropriate. Several of the people we spoke with told us that they had been given the opportunity to volunteer with the service as a peer mentor. The peer mentor training programme was comprehensive and was itself being facilitated by a former service user who was now a trained peer mentor. The registered manager told us how client involvement was ensured when changes were made, for example some planned improvements to the décor at Radcliffe House.

Clients could give feedback on the service and their treatment and staff supported them to do this. Service user feedback was collated by the provider in a spreadsheet to enable any trends to be identified. The provider also carried out a survey of people using the service and had displayed the feedback in the waiting room at Radcliffe House. The registered manager said that improving the systems for gathering feedback from people using the service and their families was a priority now they were coming out of the COVID-19 pandemic and had settled in to the new premises.

Involvement of families and carers

Staff informed and involved families and carers appropriately. We saw evidence on the records that relatives and carers were involved where appropriate. The service provided training for family members on the administration of naloxone, a drug which reverses the effects of an opiate overdose. There were also two family and carer workers employed who worked with the families of young people using the Cross Street service. The family members we spoke with said that they were happy with the level of involvement they had in their relative's care.

Are Community-based substance misuse services responsive?

Good

Access and waiting times

The service was easy to access. Staff planned and managed discharge well. The service had alternative care pathways and referral systems for people whose needs it could not meet.

The service had clear criteria to describe which clients they would offer services to and defined pathways of care for specific client groups.

The service met the provider's target times for seeing clients from referral to assessment and assessment to treatment. There was no waiting list for the service at the time of our inspection, clients received an initial screening, harm reduction advice, triage and signposting to identify if there was a priority need, the full assessment process was then completed within a maximum of three weeks of referral.

Staff saw urgent referrals quickly and non-urgent referrals within the service's target time. New clients' first contact with the service was with a triage team who carried out a full assessment of their needs and risks relating to their care, to enable prioritisation of those with the most urgent needs. Staff followed a clear pathway to identify priority needs and respond appropriately.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from substance misuse services. The service had outreach workers to target hard to reach communities and a specific criminal justice pathway where they worked closely with the police, local prisons and the probation service.

Staff tried to contact people who did not attend appointments and offer support. Staff told us that they had capacity within their caseloads to follow up people who cancelled or did not attend appointments and try to re-engage them with the service.

Clients had some flexibility and choice in the appointment times available. People using the service told us that they were offered a choice of appointment times and they were able to access the service when it was convenient for them. The service was open one evening a week to accommodate people unable to attend during the working week.

Staff worked hard to avoid cancelling appointments and, when they had to, they gave clients clear explanations and offered new appointments as soon as possible. People using the service told us that their appointments were never cancelled by the service. Appointments ran on time and staff informed clients when they did not, people told us that they were usually seen for their appointments on time.

The facilities promote comfort, dignity and privacy

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

The service had a full range of rooms and equipment to support treatment and care. Clinical appointments and one to one meetings with recovery workers took place within private, soundproofed interview rooms. People using the service told us that staff did not have confidential discussions with them in public areas of the building. The service's community café, Socialicious, which was a short walk from the Radcliffe House and Cross Street premises, provided a valuable resource for people using the service to undertake vocational training and to have an ongoing point of contact in the community once they reached the later stages of their recovery journeys. It also had a large meeting space upstairs which was used for group therapy and training.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for people with disabilities, communication needs or other specific needs. All the premises accessed by service users were fully accessible by wheelchair users and others with impaired mobility as the clinical rooms, the needle exchanges and at least some interview rooms were on the ground floor.

Staff made sure clients could access information on treatment, local services, and how to complain. Information was displayed on noticeboards in the waiting areas, including details of local support groups and information about how to give feedback on the service.

The service provided information in a variety of accessible formats so the clients could understand more easily. The service could provide written information in easy read format and had access to translation services for people who struggled to understand written English.

Listening to and learning from concerns and complaints

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

Good

Community-based substance misuse services

Clients, relatives and carers knew how to complain or raise concerns. People using the service and their family members told us that they had not needed to make a complaint about the service, but they would know how to do so if they did have any concerns.

Staff understood the policy on complaints and knew how to handle them. All the staff we spoke with were aware of the provider's complaints policy and the local procedure for dealing with complaints.

Managers investigated complaints and identified themes. The service received low levels of complaints (four in the year preceding our inspection) but the registered manager collated details of all complaints in a spreadsheet to enable any themes of concern to be identified.

We saw no evidence that clients who raised concerns or complaints experienced discrimination and harassment as a result. Everyone who had raised a complaint about the service in the 12 months preceding our inspection had received a written response following the investigation of their concerns.

Managers shared feedback from complaints with staff and learning was used to improve the service. This was done on a one to one basis at supervision meetings and also more widely through team meetings and governance meetings.

The service used compliments to learn, celebrate success and improve the quality of care. Compliments were collated with other patient feedback, fed back to the staff members involved and shared with the wider team.

Are Community-based substance misuse services well-led?

Good

Leadership

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

The service had a registered manager in post at the time of our inspection. Other members of the senior management team included an operations manager, a quality and governance manager and a clinical lead. All the staff we spoke with said that both their immediate managers and senior managers were approachable and accessible to them. All the members of the management team demonstrated a good understanding of all aspects of the service, across all the different premises and care pathways. The registered manager based herself at different premises throughout the week to improve her accessibility to staff across the service. Senior managers attended regional meetings within the provider organisation and shared information from these with staff.

Vision and strategy

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

All staff received an induction workbook when they started working for the organisation which included information on Turning Point's vision and values. Staff told us that they were aware of the vision and values and these were meaningful

to them in the context of their day to day work. We saw evidence in the care we observed of staff working within the stated values, for example treating people as individuals and respecting people's potential. The registered manager described how the staff recruitment process included a values based assessment and how ongoing behaviour in support of the service's values was identified and promoted through the supervision and appraisal process.

Culture

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

All the staff we spoke with told us that they felt well supported by the provider, senior and immediate managers and colleagues. Staff described strong morale within their teams and said that they enjoyed coming to work and felt valued in their roles. Some members of staff described how they had previously been service users and then peer mentors before commencing a paid role within the team. The provider offered opportunities for career progression and relevant training, for example management and communication skills courses. Staff spoke positively about the move to the Radcliffe House premises and were enthusiastic about plans for future development of the service.

The provider carried out pulse surveys to gain feedback from staff on particular topics. The most recent survey prior to our inspection had related to staff wellbeing and inclusion. The feedback from this was mostly positive and the provider had developed an action plan in relation to areas for improvement highlighted by the results, for example to increase staff awareness of career development opportunities. The staff we spoke with told us that they did feel they were able to make suggestions for improvements within the service, although some staff said they were often too busy with client work to focus on strategic issues.

Staff told us they felt able to raise concerns. They were aware of the service's whistleblowing procedure and knew who to speak to if they wanted to raise concerns anonymously. There was a process within the provider organisation for staff to raise concerns separately to their local service if they did not feel able to speak to one of the local managers.

Governance

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

The provider carried out a range of audits to monitor the quality of the service and the outcomes from audits were discussed at team meetings and also at regional governance meetings. Other performance data was reviewed at governance meetings, including compliance with key performance indicators and commissioner targets, untoward incidents, safeguarding concerns, complaints and other feedback from people using the service.

Action plans were put in place in relation to areas for improvement, for example performance at a level below target or concerns identified by audits. Individuals were identified to lead on specific actions and progress against the plans was monitored at governance meetings.

Management of risk, issues and performance

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

There was a local risk register for the service on which key clinical, operational and business risks were documented. The registered manager kept this under review, ensuring it was updated as the level of risk changed. For example, the risks relating to the COVID-19 pandemic in relation to infection prevention and control, clinical risk management and staffing had been kept under regular managerial review and mitigation measures put in place as far as possible.

Managers carried out thematic reviews of service user deaths over each 12 month period, producing a report identifying any themes of concern or lessons learned, together with any service improvements indicated as a result of the review. Client deaths were also reviewed in detail at a monthly mortality and morbidity review meeting to ensure any concerns with the service provision would be identified promptly.

Information management

Staff collected and analysed data about outcomes and performance.

The provider used an internal quality assessment tool to monitor performance and compliance with regulatory standards. This was updated on an ongoing basis and reviewed at regular internal governance meetings.

The service also submitted quarterly reports to Wakefield Council, its lead commissioner, providing updates on performance against key indicators and an overall risk rating for performance. The commissioner's reports also included detailed information on achievements and concerns from the reporting period, an overview of safeguarding issues identified and a summary of significant risks and anticipated future challenges.

Managers were able to access performance data at any time through the provider’s intranet and we saw evidence from team meeting minutes that performance data was shared with staff, both to celebrate achievement and to identify areas for improvement. The registered manager attended regular registered manager forums with other registered managers across Turning Point’s substance misuse services which enabled the sharing of good practice between services.