

Turning Point Rochdale and Oldham

Quality Report

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Rochdale

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

Ratings

Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Good 

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.

Summary of findings

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

Overall summary

We rated Turning Point Rochdale and Oldham as good because:

- The service's premises, including clinic rooms, were clean, tidy and had the appropriate equipment needed to provide quality care and treatment.
- The service provided a range psychological intervention pathways and worked well with other agencies. Staff kept comprehensive care and treatment records that included risk assessments and risk management plans.
- Staff were skilled, knowledgeable and suitably qualified. They were positive and proud to work for the service. Managers were supportive of staff. They had a strong focus on staff wellbeing and updated staff regularly with information relating to the service
- Clients told us they felt supported and were treated with dignity and respect. Staff involved clients in the planning of their care and treatment and the service adapted appointments to meet the needs of the client.
- Turning Point Rochdale and Oldham were taking part in a Foetal Alcohol Syndrome pilot through a Greater Manchester Health and Social Care Partnership programme, and part of the Greater Manchester Population Health Plan initiative.

However:

- Meetings between clients and staff were sometimes disturbed by staff looking for vacant rooms.

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 summaries.

Summary of findings

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Good 

Turning Point Rochdale and Oldham

Services we looked at

Community-based substance misuse services

Summary of this inspection

Background to Turning Point Rochdale and Oldham

Turning Point Rochdale and Oldham is a community substance misuse service that is registered to provide the regulated activity treatment of disease, disorder or injury to clients over the age of 18 years. The service offers a variety of support interventions for people that are affected by drugs and alcohol. Interventions include a range of group work, one to one recovery worker support, substitute prescribing, health and wellbeing, harm reduction, relapse prevention, needle exchange and support with employment and housing. The service also offer support for families and carers. Detoxification is provided at the service in a combination of ambulatory and home detoxification.

The service has a registered manager in place and is co-commissioned by Rochdale and Oldham councils.

The service operates from two locations, Oldham and Rochdale and is open five days a week, Monday to Friday with one late night opening at each location.

The service was previously run by another provider. Turning Point Rochdale and Oldham has been registered with the Care Quality Commission (CQC) since 3 March 2018 and has not previously been inspected.

Our inspection team

The team that inspected the service comprised two CQC inspectors and a specialist adviser who had clinical experience of working within drug and alcohol services.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited both locations at Rochdale and Oldham, looked at the quality of the environment and observed how staff were working with clients
- spoke with five clients who were using the service
- spoke with the registered manager and locality managers
- spoke with 12 other staff members including a consultant, nurses, recovery workers, clinical lead, clinical administrator, quality adviser and psychosocial interventions lead
- attended one flash meeting with staff based at the Rochdale service
- collected feedback from 11 clients using comment cards
- looked at 13 care and treatment records of clients

Summary of this inspection

- looked at a range of policies, procedures and other documents relating to the running of the service
- spoke with 10 peer mentors
- toured each location
- carried out a specific check of the clinic rooms and medication management

What people who use the service say

Clients we spoke to told us that the service had changed their lives for the better and that staff, peer mentors and volunteers were all friendly, supportive and respectful. They felt they were treated with dignity and respect when discussing situations and sharing ideas.

Clients told us that treatment had been arranged to suit their needs and the group work has been great and very motivational.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as good because:

- The service was clean and tidy, including clinic rooms that were well equipped to provide care and treatment suitable for clients.
- There were enough skilled, knowledgeable and suitably qualified staff, including clinical staff.
- The majority of staff had completed the service's mandatory training. Any gaps had been identified by managers and plans were in place to rectify them.
- Client care and treatment records were comprehensive and included risk assessments and risk management plans.
- However:
- Client confidentiality could be compromised due to a lack of private meeting rooms during busy periods.

Good



Are services effective?

We rated effective as good because:

- Client care records were comprehensive. They included risk assessment, recovery plans and were person centred.
- The service had a large programme of psychosocial interventions based on current, evidence based practice, in conjunction with National Institute for Health and Care Excellence guidance.
- We saw good multi-agency working between the service and other community support agencies.
- Staff we spoke to had a good understanding of the Mental Capacity Act and knew where to find guidance and support when needed.

Good



Are services caring?

We rated caring as good because:

- We saw positive interactions between staff and clients. Comment cards that we received from clients stated that staff were helpful and supportive and treated clients with dignity and respect.
- Client care and treatment records showed that discussions about treatment options had been discussed and mutually agreed. Clients were able to get involved in the care the service provided. Peer mentors had been involved with the recruitment of staff by forming part of the recruitment panels.

Good



Summary of this inspection

- Family and carers were offered support through psychosocial intervention group work.

Are services responsive?

We rated responsive as good because:

- The service worked well integrating clients into the community and providing support with accessing employment, education and training opportunities.
- Appointments and groups were adapted to meet the needs of clients.
- Information leaflets, policies and procedures had been translated into other languages to meet the needs of the client base.
- The service had a robust customer feedback policy and clients were encouraged to give feedback through one to one sessions, feedback forms and suggestion boxes that were in the reception areas.

Good



Are services well-led?

We rated well-led as outstanding because:

- The service was taking part in a Greater Manchester Health and Social Care Partnership programme which included part of the Greater Manchester Population Health Plan Initiative, for a Foetal Alcohol Syndrome pilot.
- Managers had a good understanding of the services they managed. They were knowledgeable, and they had good levels of skill and experience to enable them to lead their teams.
- Senior managers had a high presence within the service and staff felt they could approach them for advice and guidance when they needed to.
- Managers had created a culture of pride and positivity within the staff team. Staff told us they could see the service going from strength to strength and managers made sure updates relating to the service was fed back to staff through newsletters and team meetings
- Managers ensured that staff had access to equipment and information technology they needed to carry out their roles.
- Senior managers were involved in several national support forums relevant to the service.
- The service was focusing on the wellbeing of staff and had appointed some staff as wellbeing champions to meet monthly and develop a wellbeing action plan for staff.

Outstanding



Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act training was mandatory for all staff. At the time of inspection, 95% of staff had completed the training.






Staff we spoke with were able to discuss their understanding and role in relation to the Mental Capacity Act.

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	 Outstanding	Good
Overall	Good	Good	Good	Good	 Outstanding	Good

Community-based substance misuse services

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

Are community-based substance misuse services safe?

Good 

Safe and clean environment

Both locations were clean and tidy throughout and the furnishings were well maintained. During inspection we raised that although the service was visibly clean, there was no log to assure that cleaning was being done regularly. The service took immediate action to rectify this.

There were two clinic rooms at each location. All were clean and tidy and were well equipped to provide physical examinations. The service was able to provide clients with electrocardiogram (ECG) testing. Room and fridge temperatures were checked daily.

Needle exchange facilities were available at both locations. No controlled drugs were kept on the premises. The service did keep naloxone for distribution to clients at risk of overdose. This was stored securely.

The service had a health and safety lead at each location and two fire marshals. Fire marshal and evacuation information was displayed on staff notice boards in the staff office and client notice board in the reception areas. Health and safety assessments, including fire risk assessments, were done regularly following the organisation's policies and procedures and the service had a clear evacuation plan.

Staff adhered to infection control principles, including handwashing. Posters were displayed at hand basins on how to wash correctly. The service had appropriate facilities to dispose of clinical waste, including sharps bins.

Safety of the facility layout

The service at Turning Point Rochdale was a two storey building. Clients had access to the ground floor, which included two clinic rooms, toilets, a screening room, meeting rooms and a large reception area. The first floor was used only by staff. A fob was used to access the first floor and clinic rooms required keyed access.

Turning Point Oldham was a three storey building. Clients used the ground and first floor for one to one sessions and group work. The service had two clinic rooms on the ground floor. The second floor was for staff. Only staff had access to this area using a fob.

Both locations were accessible for wheelchair users and had accessible rooms and toilet facilities on the ground floor. Staff were able to offer home visits or meet at a community facility, for example, GP surgery if the client preferred this.

There was a shortage of space for private rooms for meetings between staff and clients at both locations during busy periods. During inspection, saw staff knocking on room doors trying to find a vacant room.

All staff were provided with panic alarms and the clinic rooms and meeting rooms had alarm calls on the wall.

Signage notified visitors that CCTV was in operation in the communal areas.

There was a secure entry system for clients entering the building at both locations.

Community-based substance misuse services

Safe staffing

Turning Point Rochdale and Oldham had 65 staff overall. There were no vacancies at the time of inspection.

The service had used agency staff during a period of recruitment to maintain safe staffing levels. Agency staff received a full induction and supervision.

All staff were DBS checked in line with the organisation's guidelines. Support was provided for all staff during employment probation periods and they were signed off by managers once competency had been demonstrated.

The service had a team of qualified clinical staff including a clinical lead and clinical services manager.

Staffing levels and mix

Staffing levels were determined by caseloads. Caseloads were based on 70 per recovery worker. Managers told us that caseloads were reviewed fortnightly and audited monthly. The service had a robust recovery coordination policy to help ensure a caseload balance for staff.

To help reduce the amount of one to one sessions, managers encouraged group sessions. We saw a variety of groups available that were led by psychosocial intervention staff and peer mentors in line with the National Institute for Health and Care Excellence (NICE) guidelines.

Meetings were held each morning with all staff to provide updates, identify risks and discuss the activities for the day. We saw that staff were able to discuss risks freely and agree on actions. These were called flash meetings.

Mandatory training

All staff received mandatory training in a range of face to face and online learning. We saw that mandatory training was being monitored daily. At the time of inspection, the overall compliance for mandatory training was 86% for all staff.

Ninety-five per cent of staff had received training in the Mental Capacity Act and staff we spoke to understood their responsibilities.

We were assured that any gaps in training had been booked in for completion.

Assessing and managing risk to patients and staff

All clients receiving treatment at the service were allocated a recovery worker to support them.

All prescribed clients received a comprehensive assessment that included risks, on commencement of treatment. The assessments comprised information from GPs, physical health, mental health, social factors and screening prior to treatment. All prescribed clients were reviewed every 12 weeks or sooner if needed.

Non prescribed clients received a wellbeing assessment with a nurse or health care assistant. The assessment focused on risk factors including health, family and social factors to identify if referral was needed to other sources of support such as primary care.

We looked at 13 sets of care and treatment records. Each included up to date risk assessments, risk management plans including plans for unexpected exit from treatment. The care and treatment records showed that information had been shared with appropriate agencies, such as social services, where required.

The service had a clear lone working policy and procedure. Home visit forms were completed prior to visits and any risks were raised with managers and discussed at morning meetings with all staff.

Safeguarding

Safeguarding training was mandatory for all staff. At the time of inspection 91% had completed safeguarding level one and 90% had completed safeguarding level two.

The service had a safeguarding lead and six safeguarding champions. Pregnant clients were usually allocated the safeguarding lead as their recovery worker. The safeguarding lead linked in with other agencies such as social services and local hospitals to determine perinatal treatment pathways.

Safeguarding assessments were completed with clients that had contact with children. These were reviewed by managers and support provided to staff when making referrals for adults and children to the multi agency safeguarding hub (MASH) or the early help and safeguarding hub (EHaSH). We saw that safeguarding cases were being reviewed regularly.

We saw evidence of good communication links with local safeguarding teams in client care records.

There were monthly safeguarding meetings with the safeguarding champions and monthly complex case reviews at both locations.

Community-based substance misuse services

There were three safeguarding notifications made to the Care Quality Commission (CQC) over the last 12 months.

Staff access to essential information

Staff had access to all information they needed that was relevant to their role. All information was stored electronically, and staff used personal encrypted log in detail to access the systems securely.

Medicine management

We saw good prescribing cover across the service. The service had four doctors and two non medical prescribers. At the time of inspection, an additional two non medical prescribers had been recruited. Client notes were stored electronically and were accessible to staff at either location. Clients were able to collect prescriptions themselves from an agreed pharmacy.

The service ensured that blank prescriptions were stored securely with access restricted to prescribers. Completed prescriptions were delivered securely directly to community pharmacies. This had been a major change in process from the previous service provider and the clinical leads had developed procedures to ensure changes to prescriptions, including dose changes and changes to dispensing arrangements, were managed smoothly. Progress and challenges were monitored at clinical administration meetings with an ongoing action plan maintained.

The service did not keep any controlled drugs at either location.

The Turning Point prescribing policy reflected current guidance and best practice, including National Institute for Health and Care Excellence guidance, Department of Health drug misuse and dependence guidelines and national patient safety alerts. Specific prescribing guidance was in place nationally to guide clinicians in prescribing opioid substitutes, injectable opioids, medicines for opioid and alcohol detoxification and monitoring and medicines to support abstinence from alcohol and opioids.

The clinical lead had a home office licence for continued prescribing for a small number of clients who were prescribed injectable opioids.

Meetings were held regularly to review prescribing.

Turning Point had also developed guidance for clinicians in relation to drug screening, driving requirements and guidance in completing holiday prescriptions and documents.

Clients were offered blood borne virus (BBV) screening. All clients were routinely risk assessed for risk of blood borne virus and all clients were offered blood borne virus screening via blood spot testing. Hepatitis B vaccinations could be given if required by healthcare nurses.

A health care assistant at the service was able to provide clients with additional support on a range of health and wellbeing issues, such as BBV screening, needle exchange, sexual health, smoking cessation advice and the supply of naloxone. Naloxone is used reverse the effects of opiate overdose. We saw staff were encouraging clients to be trained in the usage of naloxone and be provided with a pack.

We saw good clinical housekeeping activity such as management of stock and clinical housekeeping checklists and risk assessment.

Track record on safety

At the time of inspection, the service had a total of 1922 clients receiving treatment. There were 60 serious incidents reported to CQC over the last 12 months. All of these were deaths. None of the deaths were on the premises and all were followed up and reviewed in line with service policy.

The service held morbidity and mortality meetings monthly to identify areas of good practice.

Reporting incidents and learning from when things go wrong

Staff we spoke with knew what incidents to report and how to report them.

The service used an electronic system to log all incidents, complaints and compliments. The system allowed for staff to report incidents in real time which triggered an automatic notification to senior management and clinical staff within the service. Managers were allocated to handle incidents until resolved. We saw incidents were being discussed at team meetings to share learning.

Data was being monitored regularly. The system allowed for reports to be extracted in real time or by specific date ranges. These were being used to identify learning needs and themes.

Community-based substance misuse services

Are community-based substance misuse services effective?

(for example, treatment is effective)

Good 

Assessment of needs and planning of care

We looked at 13 sets of care records. Each had evidence of comprehensive, holistic assessments of clients' needs, including references to National Institute for Health and Care Excellence guidance.

Physical health assessments were up to date and recovery plans were person centred. Both were reviewed regularly.

We saw documented evidence of good multi agency working with GPs, learning disability teams and community mental health teams and the involvement of family members or carers.

Staff told us that clients on injectable medicines and clients on high dose methadone or high risk combinations were prioritised for medical reviews and electronic cardiograms.

Best practice in treatment and care

Following the service registration, the senior management had identified significant differences in shared care arrangements with general practitioners. The managers and medical director for the organisation had worked with local GPs to develop an effective, comprehensive pathway for shared care. This ensured that GPs could access specialist training and advice and that clients' care and monitoring was regular and consistent across all practices.

The pathway reflected both National Institute for Health and Care Excellence guidance and Royal College of General Practitioners' guidance for primary care opioid dependence substitute prescribing.

Staff told us they engaged in clinical audits that took place monthly.

Clients were supported to live healthier lives. Wellbeing assessments were being carried out by a nurse or health care assistant. Discussions were documented in client care records and clients had access to a range of information leaflets, including directing clients to other local support groups.

We found that the service had provided information to clients about the constituents of medicine to ensure they met clients' religious requirements, such as halal medication. The service had medication printed in different languages to suit clients' needs.

We saw forward planning for clients going on holidays with prescriptions and documentation arranged in advance when travelling to other countries. This included forward planning for religious holidays, such as Ramadan.

The service had a large programme of psychosocial interventions based on current evidence and National Institute for Health and Care Excellence guidance. The programme was offered to clients through group work or on a one to one basis.

The service had a psychosocial intervention lead and group lead that provided group supervision to all facilitators. The team held 'model of psychosocial interventions' (MOPSI) meetings every three weeks to ensure the team were appropriately supported and updated on group material. The psychosocial intervention lead received regular supervision from the organisation's head psychologist.

Skilled staff to deliver care

The service had enough staff with the right specialisms to meet the needs of the clients.

The clinical staff were appropriately trained and qualified and consisted of doctors, registered general nurses, mental health nurses and non medical prescribers.

All staff, including agency staff, received a full induction that included mandatory training during their six month probation period. Staff were only signed off their probation period once competency had been assured.

Supervision and appraisals were provided to all staff every four to six weeks. Staff experiencing any performance concerns were offered coaching and additional training.

Managers held regular meetings to monitor and discuss caseload management.

The service offered a comprehensive accredited eight week training programme for peer mentors.

At the time of inspection, there was 21 peer mentors and 13 volunteers. They were providing support in several areas

Community-based substance misuse services

including co-facilitating groups, front of house support, supporting staff on home visits, admin duties and general client support such as making calls to housing and attending appointments.

Supervision was provided by a peer mentor and volunteer coordinator.

The service held a graduation event for peer mentors that qualified in December 2018.

Multi-disciplinary and inter-agency team work

The service had a multi-disciplinary team that covered the boroughs of Rochdale and Oldham. The staff were led by the senior operations manager who was also the registered manager for the service. Clinical activity within the service was overseen by a registered clinical lead and clinical nurse manager.

Staff shared important information about clients at daily flash meetings.

The service had a partnership team and a community development worker that had identified a range of services available for clients in the community and would make referrals when required.

The partnership team had taken part in a range of promotional events across the boroughs.

We saw good multi-agency working between the service and community mental health teams, alcohol liaison teams, GPs, probation, homeless support agencies, safeguarding teams, housing support and migration agencies.

The service collected and submitted information to the national drug treatment monitoring system dataset. The information was used to evaluate performance and commissioning reviews.

Good practice in applying the MCA

Staff we spoke with had a good understanding of the Mental Capacity Act and knew where to find guidance and support when needed.

At the time of inspection, 95% of staff had completed the training.

All 13 records we looked at showed consent to treatment had been sought from the clients.

Are community-based substance misuse services caring?

Good 

Kindness, privacy, dignity, respect, compassion and support

We saw positive interactions between staff, peer mentors, clients and volunteers. Staff were respectful and supportive towards clients.

Recovery plans we looked at included client views. They were holistic and had identified clients' strengths and goals.

We received feedback from 11 clients using comment cards that had been placed at the service locations prior to and during inspection. Clients used the cards to tell us that staff were helpful and supportive and treated clients with dignity and respect. Some clients said that they wished they had started at the service sooner and they felt safe. However, one complained that the 0300 number for the service was expensive to call, especially when placed on hold. Another stated that water should be made available in the client waiting area at Rochdale.

Involvement in care

The care and treatment records we looked at showed that clients were fully involved in their care planning and risk assessments and there had been discussions about treatment choices. We observed a client meeting with a consultant and saw that the client was fully involved. There was a good level of communication throughout.

Peer mentors had been involved with the recruitment of staff by forming part of the recruitment panels.

Suggestion boxes had been placed at the reception areas at both locations for staff and clients to use and there were regular client forums.

Staff surveys were used to gather feedback from staff. We saw that the results were discussed at 'you said, we did' meetings.

There had been a recent survey to gather staff feedback about the possibility of opening the service on a Saturday. Managers told us they were planning to trial it in the future.

Community-based substance misuse services

Families and carers were offered a '5 step' psychosocial intervention on a group basis. The need for this was being assessed during client assessments. With the client's consent, support was available for their families and carers while the client was receiving treatment. Additionally, staff made referrals to external family and carer support services.

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

Good 

Access and discharge

Assessments were completed within one to two weeks of referral. Clients were able to make self referrals.

All calls were directed to a central headquarters support service, made up of a small team of advisers that were trained to assess and direct new referrals to appropriate locations. We had received concerns from clients that it was costly for them to be placed on hold waiting to get through. The service acknowledged the rise in the number of calls had impacted on the time it took to answer calls. Additional staff were being recruited to support demand and improve response times.

The service was open five days a week, Monday to Friday with one day open until late at each location.

Staff tried to make follow up appointments with clients that failed to attend. This was done through phone calls, mail or home visit if appropriate.

Client recovery plans incorporated referrals to a range of partner agencies, such as housing, employment and education, to support the client during and after treatment at the service.

Additionally, the service had an aftercare support programme that provided clients with service engagement for up to six months and online support for up to one year post discharge.

The facilities promote recovery, comfort, dignity and confidentiality

The service was clean, tidy and had appropriate equipment to support treatment and care for clients. However, there may not always be enough private rooms available for clients to have one to one sessions with their recovery worker. During inspection, we saw staff knocking on doors during appointments to see if the room was vacant or not, which could have an effect on confidentiality.

Patients' engagement with the wider community

The service had a community development worker and an employment, training and education (ETE) worker to assist with integrating clients into the community and provide support with accessing employment, education and training opportunities.

Clients were encouraged to develop and maintain relationships within the service and the wider community.

Meeting the needs of all people who use the service

The service had introduced new starter assessment clinics at both locations, on Mondays and Wednesdays. They included initial assessments, health screening and support options to make access to treatment quicker.

The service was flexible in meeting the needs of their clients. Clients told us they were happy that the service was able to offer appointments to work around them due to other commitments such as work and children.

Psychosocial intervention group times had been changed to allow clients with children to attend within school hours. The service had also changed the times of some groups to fit around prayer times.

Both locations were accessible for people with disabilities. However, access was limited to the ground floor.

There was a variety of information leaflets in the client waiting areas that were available in other languages and large print.

The service provided translation services for client assessments and treatment.

The service had easy read policies and procedures had been produced in Urdu, Bengali, and Polish.

Listening to and learning from concerns and complaints

Community-based substance misuse services

The service received 14 complaints in the 12 months prior to 9 May 2019. Eleven were informal and three were formal. All were resolved following Turning Point's customer feedback policy. The policy set out a framework for the management of compliments, suggestions and complaints.

Clients knew how to complain or raise concerns. Customer feedback forms were available from reception at each location along with boxes for completed forms.

Compliments and complaints were analysed and recorded onto the incident reporting system and any learning from these were shared at team meetings and clinical governance meetings

The service planned to install 'you said/we did' client boards at each hub location to communicate feedback and inform clients of improvement actions in response. The service planned to have this led by a peer mentor or volunteer.

Clients we spoke with told us they felt safe and could raise concerns if they needed to.

Are community-based substance misuse services well-led?

Outstanding



Leadership

The managers we spoke to had a good understanding of the services they managed. They were knowledgeable about how the teams worked and they had good levels of skills and experience to enable them to lead their teams.

Senior managers were visible in the service and were approachable for clients and staff.

Staff told us that senior managers had a high presence within the service and staff felt they could approach them for advice and guidance when they needed to. The registered manager held staff engagement lunches to give staff the opportunity to speak out and share any areas of concern about the service.

Leadership development opportunities were available. The operations manager, psychosocial interventions lead, and the engagement team lead had enrolled onto a

management foundation programme, so they could enhance their current skills and knowledge. Other first line managers were to be enrolled on the course through the year and into 2020.

The psychosocial interventions lead was receiving cognitive behavioural therapy supervision with an external accredited psychotherapist. This was to ensure that their skills and knowledge were up to date and compliant with National Institute for Health and Care Excellence guidelines and the British Association for Behavioural and Cognitive Psychotherapies (BABCP) recommendations.

Vision and strategy

Staff had the opportunity to contribute to discussions about the strategy for their service as it was developing.

The service was in the process of developing the vision and values and were planning to have staff away days to gather staff contributions.

Culture

Staff felt respected, supported and valued. We saw staff surveys being used to monitor staff wellbeing. This was a useful tool for managers because a number of staff had transferred from another provider under the Transfer of Undertakings (Protection of Employment) Regulations 2006. Managers were able to identify areas that required more focus. A result of this was introducing staff away days, engagement lunches with the registered manager and targeted workshops to support staff development. Staff and managers were able to get support from Turning Point's central change facilitators to help embed new approaches and operational changes.

Staff told us they had seen a big improvement in the quality of the service since it had changed provider. They told us there had been a lot of discontent at first, but it was now a happy environment to work in and staff felt their managers were very supportive.

Staff felt able to raise concerns without fear of retribution.

Staff felt positive and proud about working for the service and their team. Staff told us they could see the service going from strength to strength.

Managers dealt with poor staff performance when needed. Performance was recorded daily on the services electronic system and managers held monthly performance meetings to discuss action plans.

Community-based substance misuse services

The provider recognised staff success within the service. Staff were able to nominate other staff for awards in recognition of their achievements. Staff awards took place at the away days.

The service had recently appointed some staff as wellbeing champions who were meeting monthly to develop a wellbeing action plan for staff.

The service held staff away days, once every quarter. At the away days, staff received awards based on appreciative colleague feedback.

Employee assistance was available for staff and wellbeing advice emails were circulated regularly.

Governance

It was clear that the service managers were focused on improving the quality of service delivery and staff wellbeing.

There were systems and procedures to ensure that the premises were safe and clean.

The service had enough staff to deliver quality care and treatment. Managers were monitoring staff completion of mandatory training and staff received regular supervision.

Client care records showed that comprehensive assessments were being done and clients told us they felt safe, supported and happy with the service.

Staff knew what incidents to report and could log incidents from any location in real time. We saw the service had a clear procedure for investigations incidents and were providing feedback to staff regularly.

Staff participated in clinical audits. We saw that the audits were enough to provide assurance and staff acted on the results when needed.

Management of risk, issues and performance

The service held monthly meetings attended by the performance manager, senior operations manager, locality managers, clinical services manager and senior recovery workers to look at live performance data, key performance indicators and service targets that were then placed on to the service performance action plan.

Flash meetings took place each morning with all staff to ensure that all activities for the day and any risks identified were managed and escalated if needed.

Weekly team meetings reviewed complex cases, performance, safeguarding and incident reviews to share learning within the teams and to escalate to other meetings including the management team meeting, complex case meeting, clinical governance meeting and mortality and morbidity meetings. Performance data, such as caseload compliance, safeguarding assessments and prescription reviews was fed back through regular team meetings or at supervision.

Audits were completed each month for caseloads, clinical, safeguarding and prescribing.

Clinical, safeguarding, caseload and prescribing audits were carried out each month.

Service performance was being reviewed quarterly at contract review meetings attended by commissioners and senior management.

Information management

We saw that staff had access to the equipment and information technology they needed to carry out their roles. Staff had secure electronic access to client case notes from either location and could update the records in real time. However, the telephone system (where calls were directed to a central point for distribution) was causing delays in response times and clients told us this was costly for them.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and client care.

Information was in an accessible format, and was timely and accurate. Managers were able to print off report in real time or for specific dates to identify areas for improvement.

Staff knew what to report and made notifications to external bodies when needed.

Engagement

Staff were kept informed of activity relating to the service through newsletters and team meetings. Staff told us they had plenty of opportunities to give feedback and input about the service.

Clients were able to give feedback on the service through forums and suggestion boxes. The service had adapted group session times and was open until late one night a week, as a result of feedback from clients.

Community-based substance misuse services

Managers informed us that a survey had been completed with clients about the possibility of opening on a weekend in addition to the late night opening. The results were being analysed at the time of inspection.

The service planned to have a 'service user feedback week' each quarter to track progress and ensure client engagement was maintained.

Senior managers were involved in several national support forums including Turning Point's registered manager forum, safeguarding lead meetings, nurse manager forums and national prescriber meetings and national psychology meetings.

Learning, continuous improvement and innovation

The service was taking part in a Public Health England (PHE) Foetal Alcohol Syndrome pilot being rolled out across Oldham and Rochdale. The plan was to deliver two specific interventions to women of a fertile age with referral to contraceptive interventions locally. Information received from the service informed us that eight staff had been trained to deliver the interventions that were overseen by the safeguarding lead.

The service participated in accreditation schemes relevant to the service. They had recently achieved a gold standard from Investors in People (accreditation for people management).

Outstanding practice and areas for improvement

Outstanding practice

Turning Point Rochdale and Oldham was taking Greater Manchester Health and Social Care Partnership programme which included part of the Greater Manchester Population Health Plan Initiative, for a Foetal Alcohol Syndrome pilot being rolled out across Oldham

and Rochdale. Eight staff at the service had received training to enable them to deliver interventions to women of a fertile age, including referral to contraceptive interventions locally.

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should ensure that an effective system is in place for staff to book meeting rooms and/or clearly indicate that they are in use, so that private appointments are not disturbed by staff looking for vacant rooms.