Turning Point - Leigh Bank

Quality Report

4 Glebelands Road
Prestwich
Manchester
M25 1NE
Tel: 0161 773 1523
Website: http://www.turning-point.co.uk/leigh-bank.aspx

Date of inspection visit: 25 and 26 April 2016
Date of publication: 03/08/2016

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

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

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

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

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

Overall summary

We do not currently rate independent standalone substance misuse services.

We found the following areas of good practice:

- Leigh Bank's environment was safe and homely. Staff carried out regular health and safety and environmental risk assessments. There were sufficient staff on duty: staff were available to support clients on site during the day and by telephone out of hours. Care records contained a person-centred risk assessment and management plan. Incidents were investigated and lessons learned were fed back to staff. Staff were well supported to provide safe care.
- Clients identified their own recovery plans and staff worked with them to review their progress and goals. There was an evidence-based therapy programme to help clients recover from drug and alcohol dependency. Staff worked closely with a local GP to manage clients' physical health needs. Staff had received training in the Mental Capacity Act.

Summary of findings

- Clients told us that staff were caring and approachable. Clients spoke highly about the peer mentorship scheme. Clients were involved in identifying and reviewing their recovery goals. Clients had a say in how the service was run.
- The service had developed a day rehabilitation service so clients did not have to stay overnight. Clients were able to take part in daily activities such as gardening and cooking. The building could accommodate clients with physical disabilities with ramped access and a modified en suite bedroom on the ground floor. There were no complaints but there was information for patients on how to raise a complaint and a system in place to process and oversee complaints.
- Staff were committed to improving lives and helping clients recover. Managers were approachable and supportive. Key performance indicators were used to monitor how well the service was performing. There were regular quality assessment audits and governance meetings, with outcomes being fed back to staff.

However, we also found the following issues that the service provider needs to improve:

- Urine testing arrangements did not follow best practice in infection control as they were being done on a cleared, covered desk in the ward office.
- Window restrictors in two of the rooms on the third storey were faulty. This had not been identified by the service's health and safety checks.
- Transfer and discharge plans, including information to support unexpected exits from treatment, were not completed and filed in clients' care records.

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Background to Turning Point - Leigh Bank

Turning Point – Leigh Bank is an 11-bed unit that provides accommodation and treatment for clients recovering from substance misuse. The service provides residential and non-residential psychosocial rehabilitation to males and females aged between 18 and 65 years. Clients who come to Leigh Bank have already completed a detoxification programme, which means they are no longer actively using alcohol or misusing drugs. Most clients stay at Leigh Bank for 12 weeks. Referrals usually come from community drug and alcohol teams, with placements being funded through local commissioners.

Leigh Bank is one of 82 registered services provided by Turning Point. It has been registered with the Care Quality Commission since 8 February 2011. The service is registered to provide the regulated activity - accommodation for persons who require treatment for substance misuse.

We previously inspected Turning Point - Leigh Bank on 19 September 2012 and 16 August 2013. The service was found to be meeting all the standards we looked at on these inspections.

There was a registered manager in place at Turning Point – Leigh Bank but they were absent at the time of the inspection. The provider had notified us of the absence of the registered manager. The team leader had made an application to become the registered manager and we were considering their application at the time of the inspection.

Our inspection team

The team that inspected the service comprised CQC inspector Brian Burke (inspection lead), one inspection manager and two other CQC inspectors.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme to make sure health and care services in England meet the Health and Social Care Act 2008 (regulated activities) regulations 2014.

How we carried out this inspection

To understand the experience of clients who use services, we ask the following five questions about every service:

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

Before the inspection visit, we reviewed information that we held about the location, asked other organisations for information, and gathered feedback from staff members in response to an email we asked the provider to send to them.

During the inspection visit, the inspection team:

- visited Leigh Bank and looked at the quality of the physical environment

Summary of this inspection

- observed how staff were caring for clients who used the service
- spoke with three clients who were using the service and one client who attended on a day basis
- spoke with the team leader and operational manager
- spoke with two other staff members employed by the service provider (the project worker and the support worker)
- spoke with two peer support volunteers
- spoke with a student social worker on placement at the service
- attended and observed a mood management therapeutic group and a client community meeting
- looked at five clients' care and treatment records, including medicines records
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

All of the clients who were using the service on the day we inspected told us that they felt safe and supported. They said that staff were approachable, respectful, kind and caring. Many clients said that they appreciated having access to staff in the evenings and at night through the on-call system. Clients told us the environment was homely and welcoming. Clients found the therapeutic groups and peer support to be helpful.

Clients also told us that they had received enough information before they started rehabilitation. Some took the opportunity to look around before moving in. They were aware of the requirements to remain abstinent and attend all support groups. They said that staff were respectful of their wishes (for example, whether or not to involve family or friends in their care).

Commissioners told us that Leigh Bank was engaged with the local community. They said that Leigh Bank's presence on the strategy partnership board was very helpful in terms of supporting vulnerable people. Commissioners were positive about the service's new day rehabilitation programme, which makes treatment available to non-residents.

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 do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The environment was safe and homely, with clients taking responsibility for keeping it clean.
- Environmental risk assessments had been completed in January 2016, and staff checked and maintained equipment regularly.
- Bedrooms were on three floors, which meant it was possible to accommodate clients of the same sex in separate parts of the building.
- There was a child visiting policy in place.
- Staff were available to support clients on site between 8am and 6pm and by telephone out of hours.
- All staff were fully compliant with mandatory training requirements with one minor exception, which was being addressed.
- Personnel files included evidence of disclosure and barring service checks and full employment history.
- All of the care records we reviewed contained a person-centred risk assessment and management plan.
- The service reported one serious incident in the 12 months prior to our inspection. We saw evidence that incidents were investigated and that 'lessons learned' were fed back to staff.
- Staff showed a good understanding of their responsibilities to be open and transparent with clients in relation to care and treatment.

However, we also found the following issues that the service provider needs to improve:

- Window restrictors in two of the rooms on the third storey were faulty. This had not been identified by the service's health and safety checks. This was addressed during the inspection.
- In the absence of a clinic room, urine 'dip testing' was being done on a cleared, covered desk in the ward office. This did not follow best practice in infection control.

Summary of this inspection

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Needs assessments were comprehensive and incorporated information from multiple sources.
- Clients had written their own recovery plans and had regular individual meetings with staff to review their progress and goals.
- There was an evidence-based therapeutic group programme in place, and clients were encouraged to give feedback after each session.
- All staff received regular individual supervision from their line manager and group supervision from a psychologist.
- The service worked closely with a local GP to manage clients' physical health needs.
- Individual counselling and cognitive behaviour therapy was available from independent volunteers who visited the service weekly.
- The requirements of the service were made clear to clients before they consented to admission (for example abstinence, acceptable behaviour).
- Staff had received training in the Mental Capacity Act and equality and diversity.

However, we also found the following issues that the service provider needs to improve:

- Transfer and discharge plans, including information to support unexpected exits from treatment, were not completed and filed in clients' care records.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- All of the clients we spoke to said that staff were caring and approachable. We saw staff demonstrating compassion and respect.
- Clients told us that they had enough privacy and that they had support with their individual and cultural needs.
- Clients spoke highly about the peer mentorship scheme at the service.

Summary of this inspection

However, we also found the following issues that the service provider needs to improve:

- Clients were not aware of how to access independent advocacy.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The service had developed a day rehabilitation programme in response to low bed occupancy and need in the local area.
- The service had clear admission criteria.
- There was a homely feel to the environment and clients were able to take part in daily activities such as gardening and cooking.
- The building was accessible to clients with physical disabilities with ramped access and there was a modified en suite bedroom on the ground floor.
- 'Concerns and complaints' was a standing item on the community meeting agenda, and we saw evidence that requests had been actioned by staff.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff demonstrated a commitment to improving lives and helping clients recover.
- Staff described managers as approachable and supportive.
- The provider used key performance indicators to monitor how well the service was performing.
- Staff told us that they would feel confident about raising concerns.
- Staff told us that they enjoyed their work. There was a low level of sickness so clients received care from staff that regularly worked there and rarely went sick.
- There were regular quality assessment audits and governance meetings, with outcomes being fed back to staff.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

All of the clients at the time of the inspection had capacity to make their own decisions. None were subject to Deprivation of Liberty Safeguards.

All staff had undergone mandatory training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Before clients agreed to come in to the service, they consented and agreed to the rules of Leigh Bank.

Staff described examples of times when clients did not have capacity to consent to treatment due to intoxication. They had acted appropriately to keep the client safe and/or enabled the client to make a decision at another time.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

Leigh Bank had 11 bedrooms (including one en suite), three separate bathrooms, a communal lounge/dining area, a communal kitchen, a ward office, a small interview/ meeting room and an outside garden area. Health and safety standards were set by the Turning Point risk and assurance team.

Overall, the environment at Leigh Bank was well maintained. Furniture, fixtures and fittings were fit for purpose and in good condition. Clients who used the service were responsible for keeping Leigh Bank clean and tidy, and the standard of cleanliness in communal areas was reasonable. We observed a rota, which was signed off when tasks had been completed. Staff and clients told us that any issues with cleanliness or the rota were discussed at weekly meetings. Staff completed monthly housekeeping checks. We saw evidence that a minor complaint about the cleanliness of the microwave had been resolved. There were notices in the kitchen to remind clients about maintaining hygiene, for example to cover raw food stored in the refrigerator. The temperatures of the refrigerator and freezer were recorded and displayed.

Environmental risk assessments were completed in January 2016. These included building risk, fire hazards and security of personal records and correspondence. There were no significant actions required. We saw that actions had been completed since a June 2015 health and safety audit report, for example the removal of 'clutter' from communal areas. Staff had signed to show that they had read and understood environmental risk policies, including lone working, infection control and fire safety. Staff checked fire alarms, means of escape, fire doors, and emergency lighting on a regular basis. External companies had tested appliances and serviced fire extinguishers. Evacuation procedures were clearly displayed in multiple areas around the building. Staff discussed fire safety with all clients newly admitted to the service.

All except one of the bedrooms were single occupancy. The manager told us that clients of the same sex would be able to choose to share a room if they wished and following an appropriate risk assessment. This had not yet happened. All except one of the bathrooms were shared. Clients held the key to their own room and were encouraged to keep it locked. Each bedroom also contained a lockable safe.. Only men were accommodated on the day of our inspection. Staff told us that when clients of both sexes were accommodated, rooms would be allocated to ensure that males and females were on separate floors of the property. Males and females would never be expected to share a bedroom or bathroom.

There was a comprehensive child visiting policy in place, which included consideration of potential for aggression or relapse, medication, building, parental abilities and any known concerns about the child.

We found that the window restrictors in two of the rooms on the third storey were faulty, meaning that the windows could be fully opened. This had not been identified by the service's health and safety checks. When we raised the issue with the team leader, he immediately contacted Turning Point's head office to request a contractor to fit new restrictors. The new restrictors were in place by the end of the first day of our inspection.

The service offered breath and urine screening. Clinical waste was managed in accordance with the policy and removed by a contractor. There was no clinic room in the property. The procedure for urine screening (also known as 'dip testing') was that clients produced the sample in a locked bathroom, and then handed the sample to staff. Staff would then take the sample across the foyer into the

office. Staff laid paper towels down on one of the desks and then completed the dip testing there. Although staff used personal protective equipment, they were transporting a sample and then testing in an area also used regularly by staff. These arrangements did not follow good infection control procedures for the handling and disposal of fluids and waste as outlined in the Department of Health's Code of Practice on the prevention and control of infections. There were no considerations for improvement of this issue in the service's most recent infection control audit. Managers accepted that alternative arrangements would improve infection control measures when dip testing and have since installed a shelf and clinical waste bin in the bathroom adjacent to the staff office.

Safe staffing

Leigh Bank employed six paid staff in total at the time of the inspection: a registered manager (on planned extended leave), a team leader (covering for the registered manager), a project worker, a support worker and an administrator. All were full-time apart and the administrator (two days a week). The service also was overseen by an operations manager who also regularly attended (usually one day a week). The service also offered placements to social work students and voluntary peer mentors.

The service had staff on site between 8am and 6pm each weekday, and between 10am and 6pm at weekends. The team leader usually worked weekdays only. Weekends were covered by one paid member of staff (either the project worker or the support worker) and one peer mentor. There was an out of hours telephone service to cover the hours when staff were not physically present. This on-call system was provided by the team leader, project worker and support worker. If none were available then cover was arranged from one of Turning Point's other locations.

The service had not used any bank or agency staff in the last twelve months. It had been managing the absence of the administrator by accessing additional support from another Turning Point service nearby. Planned leave was managed within the team. If the team leader, support worker or project worker was unexpectedly absent or absent for a long period then staff from other Turning Point locations would provide cover. This would also be the case if the number of clients increased significantly. Staff and clientsat the time of inspection told us that there were enough staff to cover the service. They reported that no activities or groups had been cancelled during the time they had been at Leigh Bank.

Staff underwent regular disclosure and barring service checks. Disclosure and barring service certificates were held either locally or in the central Turning Point human resources department. Personnel files included job descriptions, training certificates and identity checks. Staff files showed a full employment history, including qualifications and references from previous employers regarding suitability for working with vulnerable adults. At the time of inspection all staff who were not on extended leave had completed all mandatory health and safety training with one exception (one outstanding infection control course for one member of staff). Staff files contained certificates of attendance and records of competency (signed off by the team leader after work was observed). Peer mentors had also undergone disclosure and barring service checks and mandatory health and safety training.

All staff were fully compliant with mandatory training requirements, with one exception. This was one outstanding infection control training course for one member of staff. This was being addressed by the manager and worker concerned. The 27 mandatory training topics included safeguarding adults and children, emergency first aid at work, conflict management, assessment and recovery planning, equality and diversity, risk assessment, clinical governance and infection control. There were checks in place to ensure that staff were putting their training into practice. Staff were routinely observed during interactions with clients, with the team leader signing off competences in areas such as administration of medication and recovery planning.

Clientswere supported to register with a local GP who would prescribe or continue to prescribe medication as appropriate. Clients had lockable cupboards within their bedrooms and were encouraged to store and manage their own medication. Staff had training to be able to hold and administer medication depending on clients needs. There were no controlled drugs on the premises at the time of inspection. We viewed a policy and previous records that showed controlled drugs had been stored and checked appropriately.

Substance misuse services

Current paper care records were kept in a locked filing cabinet in the staff office, which was only opened when files were in use. Keys were accessed from a series of boxes that were themselves locked with keys or codes. Peer mentors were able to access files when needed, for example to anticipate risks during planned activities.

Assessing and managing risk to people who use the service and staff

Clients had already undergone detoxification (a course of medication that reduces the symptoms of withdrawal from alcohol and/or drugs). They had all signed an agreement to say that they would not use substances during their time at Leigh Bank. Regular breath and urine tests were used to monitor abstinence. It was clear to clients that they would be asked to leave treatment if they were identified as actively using substances. Staff described examples of when this had happened, and how they had liaised with clients' local drug and alcohol teams and social care services to ensure that clients returned home safely. Depending on clients' circumstances, a case could be made to keep a client in treatment even though they had used substances although this happened rarely.

All staff had completed training in conflict management, and clients signed a communal living and acceptable behaviour agreement at the point of admission. Clients told us that they felt safe, and that they were confident that staff could calm people down in difficult situations.

We reviewed care records for all three residents and three clients using the day rehabilitation service. All contained a person-centred risk assessment and management plan, which had been completed at the point of admission. Information from other sources (for example notes from detoxification service, hospital and GP) contributed towards a comprehensive understanding of risk. Risk assessments and management plans were accessible to all staff and peer mentors. Risk assessments were reviewed at least once every three months, and when there was a change in the client's presentation or circumstances. Risk assessments and updates were recorded in paper files and on the electronic client information management tool. All staff accessed client information management at the start of their shift.

Track record on safety

Leigh Bank reported one serious untoward incident to CQC between April 2015 and March 2016. This was the unexpected death of a client who had been discharged from rehabilitation but who was still accessing aftercare. An internal investigation was underway and there was evidence that the incident had been discussed at team meetings.

The last serious incident with a completed investigation was in June 2014. We saw evidence that lessons learned had been shared with staff and senior managers, and that changes had been implemented.

Turning Point did not routinely compare outcomes and incidents between similar services in their portfolio. This was identified as an area for improvement in the service's most recent internal quality assessment audit.

Reporting incidents and learning from when things go wrong

Staff used an electronic system to report all incidents that had or could have an impact on clients' safety. We saw paper copies of these reports, which evidenced that recording was comprehensive and appropriate. Staff understood the types of incidents that should be reported, including safeguarding, slips trips and falls, accidents, broken equipment, disputes/altercations and medication incidents. Incidents and lessons learned were standard agenda items for team meetings. Staff told us that they felt encouraged and supported to report and learn from incidents.

There had been one incident of verbal aggression and violence to property over the past year. We saw (from multiple staff accounts and meeting minutes) that staff had acted appropriately to maintain the safety of the other clients at the time, that they had reported the incident through the electronic reporting system, and that they had spent time afterwards discussing whether anything could have been done differently.

Duty of candour

Staff showed a good understanding of their responsibilities to be open and transparent with clients in relation to care and treatment. There were no recorded incidents of a level that required a formal apology to clients using services. Minutes of community meetings recorded that staff had given verbal apologies and updates when there had been problems with the location or service delivery (for example, a faulty boiler or groups not running to time).

Substance misuse services

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

Assessment of needs and planning of care

We were told that all clients newly admitted to Leigh Bank were assessed using the 'Tier 4 comprehensive assessment tool', which was a tool used across multiple Turning Point locations. The assessment in all clients' care records included information on their physical health needs (including blood borne virus and liver function), mental health needs, substance misuse history, offending behaviour and social circumstances. New admissions received a baseline physical and mental health assessment from a named local GP who was described as having a good understanding of the needs of people recovering from substance misuse problems. There was evidence of liaison with other agencies at the referral stage, for example the community drug and alcohol team, detoxification service, probation service, hospital accident and emergency department. This helped to ensure that information was accurate and comprehensive.

Each client received an induction to the service, which included a tour of the property, awareness of information sharing, confidentiality and substance testing policy, signing up to the community living agreement and local GP registration if this had not already been done.

Records showed and clients confirmed that they had been involved in assessment and care planning. Prior to admission, clients were asked to complete a 'prehab' questionnaire detailing their personal goals, support network and interests. All of the clients had an up-to-date person-centred recovery plan on their care record, with information under the headings 'who you are now' and 'who you want to become'. Clients had written the plans themselves with support from staff. Care records also showed that clients met with their assigned key worker at least once a week to review their plans, maintain commitment to treatment, manage risks and set further goals. Some clients told us that they kept copies of their recovery plans in their rooms.

Best practice in treatment and care

Leigh Bank offered a set weekly timetable, planning time for clients between 9.30am and 9pm from Monday to Sunday. There was a twelve-week rolling group programme with eight therapeutic groups each week (four sessions of recovery skills, two sessions of mindfulness and two sessions of mood management). Other planned activities included food shopping, visitor time, arts and crafts, cleaning and community meetings. There were also blocks of free time for relaxation.

The group programme included elements of cognitive behavioural therapy and dialectical behavioural therapy, both of which were intended to help clients understand and change their behaviour. The content and delivery of the group sessions followed best practice guidance from the National Institute for Health and Care Excellence (CG 51: drug misuse in over 16s: psychosocial interventions) and the framework for implementation set out by the British Psychological Society and Public Health England. Sessions were designed by the Turning Point psychology team and delivered by Leigh Bank staff. Clients were invited to give feedback following each group session, which was then communicated back to the psychology team.

We observed one mood management session. The session had a clear structure, with objectives and a review of previous sessions at the beginning. Clients talked about the techniques they had used, which suggested that the group had been effective. Staff encouraged clients to share personal experiences to inform the discussion and make the session meaningful.

Clients had one formal meeting with their key worker each week. These meetings were clearly documented in clients' notes and covered topics such as general wellbeing and progress towards personal goals. Clients using services told us that staff were available to speak to at any time, including evenings and at night by telephone.

The team leader had completed audits of care records every two months. There was a standardised audit tool including items such as contacts, housing need, drug and alcohol misuse, physical health, finance, risk assessment and signed consent. The most recent audit had identified that discharge plans needed to be updated.

The content and delivery of the therapies followed best practice guidance from the National Institute for Health and Care Excellence. However, managers accepted that there was currently no formal benchmarking against National Institute for Health and Care Excellence guidelines, for example their guidelines on drug use

disorders in adults (QS23) and the associated quality standard service improvement template. This was something the managers were looking to develop as part of the Tier 4 meetings they held.

Skilled staff to deliver care

The team leader had come from a different Turning Point service in September 2015 to cover the planned absence of the registered manager. He received monthly supervision from the operations manager, and was due to have his first appraisal in May 2016. The team leader's performance objectives were linked to the service's key performance indicators. He told us that he was looking forward to taking up the opportunity to study a level five qualification in leadership and management through Turning Point.

All staff received regular supervision from the team leader. We saw evidence that supervision had taken place at least four times over the previous six months. Supervision notes were comprehensive and covered case management, risk, service objectives, personal development and general wellbeing. Staff also received training and monthly group supervision from a clinical psychologist to support them in delivering therapeutic group programme (which was consistent with Public Health England and British Psychological Society guidance).

We saw that past minor issues with staff performance had been identified and addressed efficiently, with clear actions and review dates.

Multidisciplinary and inter-agency team work

The team leader, staff and clients who were using the service described a positive relationship with a local GP. The GP provided physical health assessments, and made referrals to other services (for example mental health services) when needed. We heard how Leigh Bank had helped one client to manage their chronic health problems with guidance from the relevant hospital team. None of the clients when we inspected were accessing support from a community mental health team. We were told that care coordinators from community mental health teams had visited clients in the past.

Individual cognitive behaviour therapy and counselling was made available to clients twice a week by a trainee cognitive behaviour therapist and volunteer counsellor respectively. Cognitive behaviour therapy and counselling were not a compulsory element of the rehabilitation programme and the therapist and counsellor were independent practitioners not employed by Turning Point.

The team at Leigh Bank liaised with other agencies to ensure that clients were supported at admission, during their stay and when they were discharged. These agencies included local authority social care, housing, employment, education, health and mutual aid groups (Narcotics Anonymous and Alcoholics Anonymous).

Adherence to the MHA

Leigh Bank did not admit patients detained under the Mental Health Act. Following a significant incident staff helped secure a Mental Health Act assessment for one client in crisis and liaised with the appropriate mental health team to help secure a hospital bed.

Good practice in applying the MCA

All staff had received mandatory training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

All clients had signed their consent to treatment, sharing of information and limits of confidentiality. When we spoke to clients it was clear that they understood their treatment and care. They knew that they were free to leave at any time.

Staff explained that clients would not be admitted to Leigh Bank if they lacked capacity. Staff described incidents where someone may have temporarily lacked capacity (for example, when intoxicated), and how they had sought support from other agencies or waited until the following day to discuss treatment decisions. The Mental Capacity Act was one of the items on the case file audit checklist.

Equality and human rights

All staff had completed training in equality and diversity. The team leader described how staff had identified that one client (from a group with protected characteristics under the 2010 Equality Act) was struggling to understand the written material from the group programme. They allocated a student to provide additional support to the client, and worked with the clinical psychologist to make the language used in future groups more accessible.

Management of transition arrangements, referral and discharge

Substance misuse services

Transition between different Turning Point services (most commonly, one of the detoxification units and one of the residential services) was facilitated by the shared client information management electronic system. This ensured that any risk assessment, needs assessment and support plans were efficiently and securely transferred over to Leigh Bank. For non-Turning Point locations, information was requested via secure fax or email.

Leigh Bank had four independent flats for clients to move onto once they had completed their treatment at Leigh Bank as part of their recovery pathway. Clients in the flats could access the services at Leigh Bank on an ongoing basis and/or work as peer mentors at Leigh Bank to assist them to remain drug and alcohol free.

Clients told us that they were confident that staff would help them to find a safe place to go if they left rehabilitation early. Clients also knew about support groups available in the local community. However, care records did not contain written transfer/discharge plans. We would normally expect such plans to include information about who should be contacted and where the client would be able to go, especially in the case of unexpected exit from treatment.

Leigh Bank routinely asked clients to complete exit questionnaires, and used the data to improve the service. They had recently started to look at long-term outcomes, asking clients' permission to contact them three months and then six months after they had left the service to find out if they were still abstinent from using substances. It was too early for any of this data to be available at the time of inspection.

Are substance misuse services caring?

Kindness, dignity, respect and support

All of the clients who were using the service told us that they found staff to be caring and approachable. Several clients told us that staff were available to help with practical matters (for example housing, making appointment with GPs) as well as providing emotional support.

We observed staff engaging with clients individually, during a therapeutic mood management group and during a more general community meeting. When the management team delivered a presentation about the service to us (the inspectors), clients were present and were encouraged to comment and contribute. Staff demonstrated compassion and respect, for example by facilitating a group that felt safe enough for clients to share personal experiences.

There was evidence that the service routinely asked clients about their cultural and other individual needs (for example as part of the 'prehab' questionnaire). Staff explained that they had supported clients to attend places of worship. They also described how they had noticed that a previous resident had become withdrawn and taken action to try to make them feel more included.

All care records contained confidentiality agreement forms, which clients hadsigned. Clients told us that they were able to speak privately to staff when they needed to. Clients said that their individual wishes about the involvement of family and friends were respected.

Clients also said that they got on well and that the groups were friendly. We observed clients sitting together and offering support to each other.

The involvement of people in the care they receive

Clients received a 'prehab' booklet prior to coming to Leigh Bank. Copies were also placed in clients' bedrooms. The 'prehab' booklet was written in an accessible way and explained the restrictions, day programme and availability of support. One of the clients we spoke to told us that he had also found it helpful to come to the service before committing to rehabilitation. This indicated that clients were given enough information to be able to make decisions about their treatment and care.

Information provided to us by Turning Point listed five sources of advocacy for clients. Clients themselves were not aware of the names of any of these groups, but told us that they had not needed to use an advocacy service, as they were confident that staff could support them and resolve problems. This was summarised by one client who told us "things get sorted quickly".

Clients using services spoke highly about the peer mentorship scheme, and one client was looking forward to starting training to become a peer mentor once they had completed rehabilitation.

We observed one community meeting and looked at records of minutes over the past twelve months. Standard agenda items included ground rules, health and safety, upcoming events, complaints and concerns, and any other

business. Actions were documented and reviewed (for example, the request for a new pet chicken to replace the one that had died). It was clear that clients' opinions about the service were respected.

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

Access and discharge

There were three clients in residential rehabilitation and four clients in day rehabilitation at Leigh Bank on the day of our inspection. The capacity of the service was eleven clients in residential rehabilitation and six clients in day rehabilitation. Bed occupancy (residential rehabilitation only) was 27%. The average occupancy during the year 2015/2016 was 48% with a target of 72%. Managers told us that the principle reasons for the under occupancy levels was financial constraints on the local authority budgets. The provider was working to improve occupancy levels through proactive contact with commissioners and previous referrers, as well as the manager having performance targets to increase the occupancy rates. Seventeen people over the 12-month period had been referred without going on to become residents; this was due to a range of reasons including lack of funding, not completing detoxification or change in circumstances.

The majority of referrals to Leigh Bank came from community drug and alcohol services and were spot-purchased by local authorities on a needs-led basis. Referrals for residential rehabilitation came from across the country. Referrals for day rehabilitation came from Bury commissioners.

The service had clear admission criteria. Clients referred to the service needed to be aged over 18 years, to have undergone a detoxification programme, to be abstinent from using substances and to be willing to engage in the treatment programme. Residential placements were either three or six months long (depending on funding and clients'personal circumstances).

The day rehabilitation service was an innovative response to need in the local area and low bed occupancy. It had been running since January 2016. Up to six clients at any one time were able to travel in from their own homes in Bury or Manchester to take part in the daily timetable of activities, including the therapeutic group programme without staying overnight. We received very positive feedback from a local commissioner and from clients using this aspect of the service.

The facilities promote recovery, comfort, dignity and confidentiality

We saw that clients had signed confidentiality and acceptable behaviour agreements. Clients told us that they were happy with the level of privacy at Leigh Bank. They were able to make private telephone calls using the office telephone or their personal mobile telephones. They could access a small meeting room away from the rest of the living space when they wanted to speak to staff. Clients were able to lock their bedroom and lock their money, medication and other personal items in a safe in their bedroom.

There was a homely feel to the property; the communal and bedroom areas were comfortably furnished and well maintained. There were facilities for cooking, laundry and gardening. The lounge had a television, books and board games, and the residents had a film and take-away night on Saturday evenings. We saw from the minutes of community meetings that charitable funds were sought for trips, and that several successful outings had taken place (for example, to the Lake District). Many of the clients we spoke to said that they enjoyed caring for the two chickens, which were kept outside. Clients could also go outside to smoke whenever they wanted.

Clients were not able to leave Leigh Bank unescorted for the first two weeks of their stay. This was to promote clients' abstinence and show commitment to the programme. They were made aware of this requirement before admission.

Service managers had attempted to get wireless broadband installed at the property so that clients could use their own electronic devices to access websites such as 'breaking free online' (a confidential online treatment and recovery programme for problem alcohol and drug use). Unfortunately, the broadband was not yet working; the operational manager stated that resolving this issue was one of his priorities for the coming months.

Meeting the needs of all people who use the service

Substance misuse services

The building was accessible to clients who used wheelchairs or had limited mobility. There was no lift to the upper floors, but all communal areas and a fully modified en suite bedroom were on the ground floor.

Clients did their own food shopping (with support if needed). This meant that they were free to make their own choices in keeping with their dietary requirements and preferences.

Family and friends were able to visit on Saturdays. There was a small room off reception for clients to see visitors including children. Clients could also receive visits in their own rooms where appropriate. The child visiting policy covered risk assessment and safeguarding for children visiting Leigh Bank.

Written information was not routinely made available in different languages or formats. Translation services could be accessed through the central Turning Point offices.

Listening to and learning from concerns and complaints

Leigh Bank had received one compliment and no formal complaints in the twelve months prior to our inspection. Staff told us that that they would record compliments and complaints on the electronic system. The electronic record enabled compliments and complaints to be overseen and discussed at senior management meetings.

Concerns and complaints were a standing item for discussion on the community meeting agenda. All of the clients we spoke to told us that they knew how to complain. They were also confident that matters would be resolved if they spoke to a member of staff. We saw evidence from the meeting minutes that informal complaints and requests had been actioned, for example a new pet chicken had been purchased and faulty light bulbs replaced.

Are substance misuse services well-led?

Vision and values

Turning Point was a social enterprise. It described itself as providing specialist and integrated services that focus on improving lives and communities across mental health, learning disability, substance misuse, primary care, the criminal justice system and employment. The website stated that Turning Point's range of drug and alcohol services help clients recover from addiction and gain control of their lives.

Turning Point's values are as follows:

- We believe that everyone has the potential to grow, learn and make choices
- We all communicate in an authentic and confident way that blends support and challenge
- We are here to embrace change even when it is complex and uncomfortable
- We treat each other and those we support as individuals however difficult and challenging
- We deliver better outcomes by encouraging ideas and new thinking
- We commit to building and strong and financially viable Turning Point together

When we asked managers and staff about Turning Point's vision and values, they spoke about the importance of recovery and their plans to provide more support to the local community.

Staff also demonstrated a commitment to improving lives and helping clients recover through the way they interacted with clients, and through the way they spoke about their roles. Staff told us that they believed they made a difference, and that the programme at Leigh Bank empowered clients by giving them life skills.

Staff knew the area manager by name. They described her as approachable and said that she attended the service regularly. The area manager had offered additional support to staff following a recent serious incident.

Good governance

Turning Point used key performance indicators to monitor how well Leigh Bank was performing. One of the main issues at the time we inspected was the bed occupancy rate. It was 27% with a target of 72%. We saw that this had been discussed at the monthly tier four meeting (a meeting for managers of the four Turning Point North West substance misuse service), and that potential solutions had been suggested and actioned (for example, the team leader building up relationships with local commissioners).

There was a range of completed audits to ensure that the service was safe and effective such as health and safety, cleanliness, involvement and care file audits. There was evidence taken to address any shortfalls identified in the audits.

Staff compliance with mandatory training was recorded on a matrix. Supervision and appraisal records were clear and accessible. We saw up-to-date policies on incident reporting, medication, customer feedback, equality and human rights, and recruitment and selection. There was a local and national risk register in place.

Leadership, morale and staff engagement

Staff described the senior management team as approachable. They knew the area manager by name, and said that she had visited to offer support after a recent difficult incident. The team leader came across as insightful about the challenges clients might face while recovering from substance misuse. He had previously worked in a mental health service in another part of Turning Point, and was able to apply this knowledge to plan additional support for clients struggling with depressed mood, anxiety and other problems.

Staff told us that they would feel confident about raising any concerns with their immediate manager or with other members of the senior management team. They knew that there was a whistleblowing telephone number easily visible in the office, but were not sure whether this linked to an internal Turning Point department or an external organisation such as CQC.

All of the staff told us that they enjoyed their work and felt as though they were making a difference to clients' lives. They said that they experienced some degree of stress, which 'goes with the job', but they felt well-supported by colleagues and managers. There was a 1.6% level of staff sickness in the 12 months prior to inspection. This meant that there were low levels of staff sickness so clients received care from staff who regularly worked there and rarely went sick.

During the inspection, we observed many examples of staff commitment and willingness to go the extra mile to provide a good service. Due to the small size of the team, staff were frequently required to offer the telephone on-call duty on an evening/night when they had already completed a full day shift. The team leader told us that he had personally cleaned a bedroom left in 'a bad state' as he did not feel it was fair to ask staff to do it. We did not speak to any carers, but there was evidence from documentation that staff had made time to support members of clients' families, even after the client had left the service.

Commitment to quality improvement and innovation

The Turning Point risk and assurance team completed internal quality assessment audits once a year. We observed the audit schedule and September 2015 action plan. The internal quality assessment audit was a comprehensive review of the service based on the five CQC domains (namely safe, effective, caring, responsive and well-led). It included all aspects of governance. We were told that any areas of concern identified by these audits would be addressed across the whole organisation as well as at a local level.

The team leader and operations manager met with senior managers and with team leaders and managers from the other three Turning Point substance misuse services in the North West once a month. The purpose of these meetings was to share learning, best practice and areas for development. We saw the action log for one meeting, which clearly outlined plans for service improvement. We felt that the day rehabilitation programme, as a response to local need and low bed occupancy, was a good example of innovative practice.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that arrangements for urine 'dip tests' are improved to meet best practice infection control guidelines.
- The provider should ensure that transfer/discharge plans, including information to support unexpected exits from treatment, are completed and easily accessible within clients' care records.
- The provider should ensure that information about advocacy services are clearly displayed in the service.