Turning Point Oxfordshire

Quality Report

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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

Overall summary

We do not currently rate independent standalone substance misuse services.

We found the following areas of good practice:

- The hub environments were clean, tidy and well lit. All appropriate health and safety records were present and in order.
- The service had adequate medical cover. There was minimal delay between referral, assessment and start of treatment. Assessments, prescription starts and medical reviews took place within 24 hours. The service responded promptly to people released from prison, offering initial assessment and bridging prescriptions as needed. A bridging prescription in this context is a prescription of methadone that is given whilst a person's care is being transferred between two services i.e. prison and a community-based service.
- Each client had an initial risk assessment and most also had a risk management plan.
- Clients received a comprehensive assessment of their individual needs and a care plan jointly formulated by them and their recovery worker. Care plans were recovery focussed, with individually formulated goals. Most care plans showed evidence of client involvement in the care planning process. Clients told us that staff had asked if they wanted family or friends involved in their treatment program.
- A full multi-disciplinary team complemented the teams of hub-based recovery workers and support workers. The provider had a dedicated safeguarding worker, based at the multi-agency safeguarding hub at Cowley Police Station. Clients had access to extensive levels of specialist employment, housing and benefits support from staff and partner agencies.
- The provider had undertaken a program of supplying Naloxone kits to clients and training them in their use, in case of methadone overdose. Naloxone is a medication administered when a patient overdoses to temporarily counteract the effect of the opiate, pending the arrival of paramedics.
- Staff followed National Institute for Health and Care Excellence (NICE) guidance when prescribing medication.
- Clients had access to a range of psychological therapies, including Cognitive Behavioural Therapy (CBT), International Treatment Effectiveness Project (ITEP) psychosocial interventions and Model of Psychosocial Interventions (MOPSI) group therapy.

Summary of findings

- New staff completed an induction program and were then assessed for their level of competence. Specialist staff training was provided on a rolling program. Examples of courses offered were drug awareness; assessment and recovery planning (including the use of ITEP psychosocial interventions); delivering MOPSI groups; harm reduction; Blood Borne Virus (BBV) testing; and, needle exchange.
- The service had been proactive in building solid working relationships with partner agencies. A new dual diagnosis pathway had been developed to enhance the relationship with mental health services, in response to a recent serious incident.
- Staff consistently treated clients in an appropriate, respectful and supportive manner. Staff demonstrated an excellent attitude towards clients when interacting directly with them, and when talking about them with colleagues. Clients had universal praise for the caring, compassionate, helpful, non-judgemental, supportive, understanding and responsive service they receive.
- Clients were encouraged to provide positive and negative feedback about the service. A newsletter written by and for clients provided them with the opportunity to impact upon service delivery.
- The service operated a comprehensive system for contacting and re-engaging clients who fail to attend appointments, and provided a "prescription collection from service hub" arrangement for clients with a history of being poor attenders.
- The service responded well to the specific needs of its clients, such as provision of specialist support for people experiencing homelessness in Oxford city centre and specific interventions for victims of domestic abuse. Also, the service operated regular satellite clinics and mobile engagement programs (as an adjunct to the four main hub offices), and offered evening and weekend services at the hub sites.
- Staff had a clear understanding of the organisation's visions and values and these were embedded into the day-to-day operation of the service.
- Staff displayed a high level of motivation for their work and a genuine passion for helping their clients. There was great positivity about the degree of progress made within the first year of the provider's contractual term.
- The service participated in a yearly review into drug related deaths. The clinical lead in public health conducted a quarterly review into deaths connected with the service.
- The service operates a peer mentor scheme and a social enterprise café to provide work-based experience for former clients.

However, we also found areas that the service provider could improve:

- There were a number of issues with the clinic room at Oxford hub: there was no record of when (or from where) stocks of Naloxone pens had been received; there were no oxygen cylinders, although a standard oxygen sign was on the door of one clinic room; resuscitation equipment was stored in a green oxygen equipment bag and there was no check list of contents or evidence that the contents had been checked; calibration of the heart rate, blood pressure and oxygen saturation monitor in the Oxford clinic room was overdue; and the ambient temperature of the clinic rooms was not monitored.
- Staff acknowledged a need to develop more support for people from black and minority ethnic backgrounds and the lesbian, gay, bisexual and transgender community.
- The needle exchange worker did not liaise with the prescriber in cases where a client was continuing to use illicit drugs to supplement their prescription.
- There was conflicting evidence on the quality of physical healthcare, assessment and monitoring. Physical examinations were not routinely carried out prior to prescribing or at medical reviews. None of the care records we examined contained evidence of a full physical health examination or assessment upon admission, or evidence of ongoing physical care monitoring. However, a nurse we spoke with, told us that staff obtain a medical history from the GP, as part of the care planning process.

Summary of findings

- Staff experience of supervision frequency was variable. Some individuals were supervised only once every six months, whilst others were supervised more than once a month. No members of staff we spoke with had received an appraisal, within the ten months that the provider had operated the service.
- One hub had two pregnant clients whose risk assessment had not been updated since they told staff they were pregnant.
- Staff knew how to report incidents, but told us that they did not receive feedback on investigations. Feedback from incidents was not a standing item on the agenda for team meetings.
- Approximately half of the 14 risk assessments we examined had been reviewed within the provider's target of 12 weeks.

Summary of findings

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Summary of this inspection

Background to Turning Point Oxfordshire

- Turning Point Oxfordshire is contracted by Oxfordshire County Council to deliver a range of community-based substance misuse services within Oxfordshire.
- They operate an integrated drug and alcohol service in four locations. The main office is in Oxford city centre, and the remaining three 'hub' locations are in Didcot, Banbury and Witney. We inspected the Oxford and Didcot hubs as part of this inspection.
- The service also operates satellite services in Henley and Bicester, along with mobile outreach services to smaller communities around the county.
- There was a registered manager in place.
- The service was registered with CQC on 07 April 2015 and provides the regulated activity of treatment for disease disorder or injury. We have not previously inspected this service.

Our inspection team

Team Leader: Steven McCourt, CQC Inspector.

The team that inspected the service comprised three CQC inspectors, an inspection manager and a nurse with a background in substance misuse services.

Why we carried out this inspection

We inspected this service as part of our inspection programme to make sure health and care services in England meet fundamental standards of quality and safety.

How we carried out this inspection

To understand the experience of people 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 people who used the service.

During the inspection visit, the inspection team:

- visited two of the four community-based 'hub' locations and looked at the quality of the environment and observed how staff were caring for clients;
- spoke with 15 people who were using the service
- spoke with the operations manager and three hub managers;
- spoke with 12 other staff members; including doctors, nurses, psychologists and recovery workers;
- spoke with four peer mentors;
- attended and observed a team meeting, a complex case meeting and a client training session.

Summary of this inspection

- looked at 14 care and treatment records, including medicines records, for people who used the service
- looked at staffing records (including training and supervision records)
- looked at policies, procedures and other documents relating to the running of the service.
- spoke with the registered manager
- received feedback about the service from care co-ordinators or commissioners
- collected feedback using 52 comment cards from people who used the service

What people who use the service say

- We spoke with people who were using the services. They were extremely positive about the services delivered by the provider and the way in which staff treated them. Clients of the service told us they felt safe and happy in relation to the service they received. Their views were matched by the carers we spoke with.
- The 52 comments cards we collected had universally positive feedback about the service and the staff.

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 areas of good practice, including that:

- clinic rooms had the necessary equipment to carry out physical examinations and to safely store medicines
- the hub environments were clean, tidy and well lit. All appropriate health and safety records were present and in order
- the provider recruited a total of more than 25 new workers since 01 April 2015. There were still several nursing and recovery worker vacancies, but the service effectively utilised a stable group of agency/locum staff in the interim
- the provider sub-contracted other agencies to provide outreach and advice services, plus some activities on their behalf
- new staff completed an induction program and were then assessed for their level of competence
- the service had adequate medical cover. Where needed, assessments, prescription starts or medical reviews took place on the same day, or the next working day.
- each client had an initial risk assessment and most also had a risk management plan
- the provider had a dedicated safeguarding lead, based at the multi-agency safeguarding hub at Cowley Police Station
- the provider had effectively assessed and managed risks associated with child visitors to the hubs
- the provider had undertaken a program of supplying Naloxone kits to clients and training them in their use, in case of methadone overdose

However, we also found areas that the service provider could improve, including that:

- surplus stocks of alcohol skin wipes and condoms were stored in the Oxford hub clinic rooms. Their expiry dates had elapsed. Upon our request, the provider assured us they would dispose of them without delay
- although staff knew how to report incidents, they did not receive feedback on investigations. However, discussions relating to recent incidents now took place within regular complex case meetings and at quarterly clinical governance meetings.
- one hub had two pregnant clients whose risk assessment had not been updated since they told staff they were pregnant.

Summary of this inspection

- the needle exchange worker did not liaise with the prescriber in cases where a client was continuing to use illicit drugs to supplement to their prescription.
- only half of risk assessments had been reviewed within the provider's target of 12 weeks
- there were a number of minor issues with the clinic room at Oxford hub: there was no record of when (or from where) stocks of Naloxone pens had been received; there were no oxygen cylinders, although a standard oxygen sign was on the door of one clinic room; resuscitation equipment was stored in a green oxygen equipment bag and there was no check list of contents or evidence that the contents had been checked; calibration of the heart rate, blood pressure and oxygen saturation monitor in the Oxford clinic room was overdue; and the ambient temperature of the clinic rooms was not monitored.

Are services effective?

We do not currently rate standalone substance misuse services.

We found areas of good practice, including that:

- clients received a comprehensive assessment of their individual needs and a care plan jointly formulated by them and their recovery worker. Care plans were recovery focussed, with individually formulated goals
- staff followed National Institute for Health and Care Excellence (NICE) guidance when prescribing medication
- clients had access to a range of psychological therapies, including Cognitive Behavioural Therapy (CBT), International Treatment Effectiveness Project (ITEP) psychosocial interventions and Model of Psychosocial Interventions (MOPSI) group therapy
- clients had access to extensive levels of specialist employment, housing and benefits support from staff and partner agencies
- specialist staff training was provided on a rolling program. Examples of courses offered are drug awareness; assessment and recovery planning (including the use of ITEP psychosocial interventions); delivering MOPSI groups; harm reduction; Blood Borne Virus (BBV) testing; and, needle exchange
- the staff team had a collectively high level of qualifications and experience and is in the process of adapting to the demands of operating a "one-stop shop" service
- regular team meetings took place at each hub. The multidisciplinary team met once a week and complex case meetings occurred once every two weeks

Summary of this inspection

- the service had been proactive in building solid working relationships with partner agencies. A new dual diagnosis pathway had been developed to enhance the relationship with mental health services, in response to a recent serious incident

However, we also found areas that the service provider could improve, including that:

- there was some initial confusion as to whether or not a Patient Group Direction (PGD) for Pabrinex was being used at the Oxford hub
- staff experience of supervision frequency was variable. Some individuals were supervised only once every six months, whilst others were supervised more than once a month.
- there was conflicting evidence on the quality of physical healthcare, assessment and monitoring. Physical examinations were not routinely carried out prior to prescribing or at medical reviews. None of the care records we examined contained evidence of a full physical health examination or assessment upon admission, or evidence of ongoing physical care monitoring. However, a nurse we spoke with told us that staff obtain a medical history from the GP, as part of the care planning process.

Are services caring?

We do not currently rate standalone substance misuse services.

We found areas of good practice, including that:

- staff consistently treated clients in an appropriate, respectful and supportive manner. Staff demonstrated an excellent attitude towards clients when interacting directly with them, and when talking about them with colleagues.
- clients had universal praise for the caring, compassionate, helpful, non-judgemental, supportive, understanding and responsive service they receive.
- most care plans showed evidence of client involvement in the care planning process. Clients told us that staff had asked if they wanted family or friends involved in their treatment program.
- clients were encouraged to provide positive and negative feedback about the service via information posters displayed on notice boards; feedback boxes on display; and regular client meetings.
- a newsletter written by and for clients provided them with the opportunity to impact upon service delivery.

Summary of this inspection

Are services responsive?

We do not currently rate standalone substance misuse services.

We found areas of good practice, including that:

- there was minimal delay between referral, assessment and start of treatment. Assessments, prescription starts and medical reviews took place within 24 hours
- the service responded promptly to people being released from prison, offering initial assessment and bridging prescriptions as needed
- the service operated a comprehensive system for contacting and re-engaging clients who failed to attend appointments and provided a "prescription collection from service hub" arrangement for clients with a history of being poor attenders
- the provider offered evening and weekend services, to meet the needs of clients
- the hub facilities had full disabled accessibility and a selection of rooms that were used for a wide variety of purposes
- an extensive selection of information was on offer for visitors to the hubs
- staff communicated with clients via their preferred methods, for example, emails or text messages
- the service responded well to the specific needs of its clients, such as provision of specialist housing support in Oxford city centre and specific interventions for victims of domestic abuse
- the service operated regular satellite clinics and mobile engagement programs, as an adjunct to the four main hub offices.

However, we also found areas that the service provider could improve, including that:

- there was a lack of support designed for people from black and minority ethnic backgrounds and the lesbian, gay, bisexual and transgender community.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found areas of good practice, including that:

- staff had a clear understanding of the organisation's visions and values and these were embedded into the day-to-day operation of the service
- staff knew the identity of senior leaders within the organisation
- managers told us they had sufficient authority to do their jobs and an appropriate level of support from senior managers

Summary of this inspection

- staff displayed a high level of motivation for their work and a genuine passion for helping their clients. There was great positivity about the degree of progress made within the first ten months of the provider's contractual term
- the service participated in a yearly review into drug related deaths. The clinical lead in public health conducted a quarterly review into deaths connected with the service
- the service operated a peer mentor scheme and a social enterprise café to provide work-based experience for former clients.

However, we also found areas that the service provider could improve, including that:

- Governance systems within the service had not served to address inconsistencies such as reviewing of risk assessments; notification of safeguarding concerns; variability of staff supervision frequencies; and issues with the clinic room at the Oxford hub.

Detailed findings from this inspection

Mental Health Act responsibilities

The provider had developed a new dual diagnosis pathway to enhance the relationship with mental health services, in response to a recent serious incident

Mental Capacity Act and Deprivation of Liberty Safeguards

The provider's parent organisation had a core policy in place for the application of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (dated July 2015), which the Oxfordshire service had adopted. In addition to the main policy, a three page brief guide on mental capacity was available for use by staff.

Staff had access to eLearning on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Some of the staff we spoke with had completed the training module.

The provider obtained consent to treatment from each individual client. Workers did not conduct a capacity assessment with clients as a matter of course. There was no evidence of mental capacity assessments in the care records we examined. That said, the evidence we saw suggested that clients generally had capacity, but that capacity might temporarily fluctuate based on use of substances and/or alcohol.

We noted evidence that the topic of mental capacity had been discussed at team meetings

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

Each hub had at least one clinic room (Oxford hub had two clinic rooms; a third room used for testing procedures; and, a room used for their needle exchange). The clinic rooms were clean, tidy and furnished with the necessary equipment to carry out physical examinations, such as dry spot testing equipment; electro-cardiogram monitors; examination couches; heart rate, blood pressure and oxygen saturation monitors; and, weighing scales.

Clinic rooms were equipped with apparatus necessary for the safe storage of medicines, such as a locked cabinet with a secure compartment for controlled drugs, and fridge. Staff checked fridge temperatures on a daily basis; however they only recorded the minimum and maximum temperature, not the actual temperature at the time of the test. The ambient temperature within clinic room was not tested, although testing kits (used to test for the presence of drugs within the body) were stored within.

Staff at the Oxford hub had used the clinic room to store excess supplies of alcohol skin wipes and condoms. However, we noted that the expiry date of all the wipes and condoms had elapsed. Upon our request, the provider gave assurance that they would dispose of the expired items without delay. The room used as a needle exchange in the Oxford hub held a supply of needles, alcohol skin wipes and condoms. We noted that the stocks were all within date.

Approximately 50 Naloxone pens (used as an emergency treatment in the event of heroin overdose) were stored in the medicines cabinet in one of the Oxford hub clinic rooms, along with two epinephrine auto-injectors (commonly known as EpiPens). All stocks were within date. However, there was no information to confirm when, or from where, stocks had been received.

There was a standard oxygen sign on the door of one Oxford hub clinic room. However, there were no oxygen cylinders within the room. In the same clinic room, resuscitation equipment was stored in a green oxygen equipment bag. There was no check list of contents or evidence that the contents had been checked, and therefore there was no assurance that items within the bag were either in date or working.

The hub environments were clean, tidy and well lit. All appropriate health and safety records were in order in the hubs. This included records for fire safety tests and equipment servicing; Legionella water testing; environmental risk assessments; clinical waste management; and control of substances harmful to health management.

Appropriate hand washing facilities were present in clinic and testing rooms.

In general, equipment was well-maintained and clean. However, a sticker on the heart rate, blood pressure and oxygen saturation monitor in the Oxford clinic room stated that it was last calibrated on 10 June 2014, with the next test due in June 2015. There was no evidence to confirm whether or not the calibration test due in June 2015 had actually taken place.

Safe staffing

The provider estimated staffing requirements for each hub as part of the tendering process for their contract to supply services in Oxfordshire. Since the start of the contractual period on 01/04/2015, the provider had recruited more than 25 new workers across the service locations.

Substance misuse services

There were six nursing vacancies across all locations and a number of vacancies for recovery workers posts. The service effectively utilised a stable group of agency and locum staff to fill the gaps created by those vacancies. The provider reported that a total of 52 shifts had been filled by agency/locum staff as at 30 November 2015.

The provider had sub-contracted Elmore Community Services to provide drop-in and outreach services for them. They had also arranged for Aspire, an employment charity, to provide work placements and advice, plus activity sessions such as the weekly boxercise class at Oxford hub on their behalf.

The provider reported a sickness rate of 4.7% (slightly lower than the national average of 5%) and a staff turnover rate of 5.8% for permanent staff as at 30 November 2015.

The provider expected all staff to complete their "foundation learning program", which included assessment and recovery planning; risk assessment and risk management; safeguarding adults and children; and, the Mental Capacity Act. New starters worked through a competence assessment pack to ensure they were able to translate their learning into practice. Competence levels were assessed via ongoing observed practice and supervision. Peer mentors were included within the training program, alongside full-time staff.

The provider showed us their rolling training schedule for 2016 and stated that their training priority areas for 2016 were emergency first aid, risk assessment and risk management and recovery planning.

The service had a full time consultant psychiatrist, who was based at the Oxford hub, but regularly visited the other locations. In addition, two GPs worked at the Oxford Hub for a combined total of three days per week. There was also a team of GPs, a pharmacy prescriber, and non-medical prescribers who collectively provided cover to each hub.

The total prescribing caseload for Oxford hub was 300 clients.

The total prescribing caseload for Didcot hub was 150 clients.

The total prescribing caseload for Witney hub was 100 clients.

The total prescribing caseload for Banbury hub was 100 clients.

The clinical psychologist managed a caseload of 12-15 clients.

The average caseload for opioid substitution therapy was 15-20 clients, which afforded the opportunity for workers to have regular one-to-one sessions with their clients.

Caseloads were managed via regular individual supervision sessions and through the individual submission of a fortnightly caseload management report.

Where needed, assessments, prescription starts or medical reviews took place on the same day, or the next working day. There was also a new dual diagnosis pathway to provide a clear framework for referrals between Turning Point and local mental health services.

A member of the management team was due to embark on a period of maternity leave in the near future. The provider had arranged appropriate cover for the service in question.

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

We examined the care records of 14 clients. Every file held a copy of a risk assessment conducted at initial assessment upon entering the service. The majority of files also had a risk management plan in place.

The provider stated that they reviewed risk assessments every 12 weeks (or more frequently if necessary). However, only approximately half of the files we examined had a risk assessment that indicated a review having taken place within the past 12 weeks.

We saw evidence that risks and risk assessments were discussed at complex case meetings, prescribers meetings and team meetings.

There were no significant concerns in relation to transport, storage or dispensing of medicines. However, we noted that the needle exchange worker did not liaise with the prescriber in cases where a client was continuing to use illicit drugs to supplement their prescription.

The provider employed a dedicated member of staff to act as a safeguarding co-ordinator. They were based at the multi-agency safeguarding hub (known as 'MASH') at Cowley Police Station. All safeguarding referrals were made through the dedicated worker, who acted as a single point of contact with all other partner agencies.

Substance misuse services

Safeguarding training was available to all members of the staff team, as part of the provider's rolling training program. Staff we spoke with were aware of the provider's safeguarding policy and knew how to raise a safeguarding alert via the dedicated safeguarding worker, based at the multi-agency safeguarding hub. However, at the time of our inspection visit, one hub was providing a service to three pregnant women and in two of the three cases, there was no evidence that their risk assessment had been updated since they told staff they were pregnant.

All the hub offices had a policy of accepting child visitors. The service had conducted an assessment of associated risks in each location and managed the risks by limiting the number of child visits where possible; arranging for clients to bring their children to the office during quiet periods; and, minimising the amount of time that children spent in public areas of the premises.

Each hub held a supply of Naloxone kits, to provide immediate treatment for heroin overdose, pending the arrival of paramedics. The provider had undertaken a program of supplying Naloxone kits to clients and training them in their use. Their stated aim was to extend the supply of kits to include carers of clients.

Track record on safety

The provider reported two serious incidents requiring investigation (SIRI) in the 12 months prior to inspection. We saw that both incidents had been investigated. As a result of one incident, Turning Point's risk management plans were reviewed and the service was working to develop closer links with local mental health teams. A new dual diagnosis protocol had been established to manage communication, including referrals, between the two services.

Reporting incidents and learning from when things go wrong

The provider utilised a computer-based system for logging incidents. Staff were able to give examples of the type of incident they would report and how they would report it. The computerised incident records we examined demonstrated that staff reported incidents appropriately.

Discussions regarding recent incidents took take place within regular complex case meetings and at quarterly clinical governance meetings. We saw evidence of changes made as a result of an incident. However, some staff we spoke with voiced concerns about a lack of robust culture of sharing and learning from incidents. Some workers told us they did not receive feedback or debriefing on incidents.

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

Assessment of needs and planning of care (including assessment of physical and mental health needs and existence of referral pathways)

We examined five client records. Every one had evidence that a comprehensive assessment of individual needs had taken place and that a care plan had been formulated in collaboration with the client. Where applicable, each file had a full assessment of the client's drug use and injecting history. Most files had an assessment of the individual's motivation to change.

Care plans took the form of a standardised three page document. They included the use of International Treatment Effectiveness Project (ITEP) program of psychosocial interventions; an individualised recovery plan (formulated per NICE guidelines); and individually formulated goals.

Best practice in treatment and care

Staff followed NICE guidance when prescribing medication.

The psychology team offered a range of therapies that adhered to National Institute for health and Care Excellence (NICE) guidance, including Cognitive Behavioural Therapy (CBT), International Treatment Effectiveness Project (ITEP) psychosocial interventions and Model of Psychosocial Interventions (MOPSI) group therapy.

The primary clinic room at Oxford hub had a folder containing a Patient Group Direction (PGD) for the administration of Pabrinex (a high dose of vitamins, administered to people withdrawing from alcohol use). However, there was confusion due to misinformation about the administration of Pabrinex on the PGD.We were subsequently informed that the PGD was no longer in use. Instead, clients were being administered Pabrinex via individual prescription.

Clients had access to extensive levels of specialist employment, housing and benefits support from members

of the staff team and partner agencies such as Aspire. Voluntary work opportunities were available through the peer mentor program; the recently opened Refresh café which was operated as a social enterprise, by Turning Point; and, Aspire's social enterprises.

We collected conflicting evidence on client physical healthcare, assessment and monitoring. One of the medical team we spoke with told us that physical examination prior to prescribing or at medical reviews were not routinely conducted. One client we spoke with informed us that their physical health was assessed as part of their initial assessment, whereas another client told us that their physical health had not been mentioned. None of the care records we examined contained evidence of a full physical health examination or assessment upon admission, or evidence of ongoing physical care monitoring. However, one of the nurses we spoke with told us that as part of the care planning process, workers liaised with GPs to obtain a medical history for the client and they then conduct an assessment of physical and mental health needs and refer to other agencies as necessary. The agreed service specification for the service operated by the provider for Oxfordshire County Council stipulated that physical health was an integral part of the assessment and care planning process.

Clinical audits were planned on an annual calendar, to correspond with quarterly clinical governance meetings. For example, a medications audit was due to take place in March 2016. One doctor informed us that audits had been carried out on the use of electro-cardiograms and the number of clients on injectable diamorphine and concentrated Methadone. The outcomes were discussed in the monthly prescribers meeting and quarterly clinical governance meeting.

Skilled staff to deliver care

The staff team covered a comprehensive range of disciplines, to support recovery workers in each hub location. The team included a consultant psychiatrist; a team of GPs; a pharmacist; nursing staff including non-medical prescribers; a clinical psychologist and four assistant psychologists; a designated safeguarding worker; and a housing support worker.

Specialist staff training was provided on a rolling program, with multiple dates arranged by an in-house training officer, in several different locations around the region, including the Oxford hub. Examples of courses offered were drug awareness; assessment and recovery planning (which includes work on the use of the ITEP program of psychosocial interventions); how to deliver MOPSI groups; harm reduction; Blood Borne Virus (BBV) testing; and needle exchange. A mixture of face-to-face and eLearning courses were available to staff.

The staff team had a collectively high level of qualifications and experience relevant to their service. However, since starting in April 2015 the provider faced a major challenge in integrating teams and transitioning from the former model of independent teams delivering only one segment of treatment for example harm reduction, to the fully integrated service now being delivered by the provider. Each individual staff member had therefore been required to embrace new learning and methods of working. Based on the feedback received from clients, this process appeared to have been largely successful.

Staff we spoke with had a variable experience of supervision. One of the medical team told us that they had only received one supervision session to date, since they were scheduled to take place once every six months. One nurse told us that they received two supervision sessions every month (one clinical and one management). Another nurse told us that nurses at the Oxford hub received group supervision every four to six weeks.

No members of staff we spoke with had received an appraisal since the commencement of the service in April 2015. There was no appraisal plan available for the forthcoming year.

Regular team meetings took place at each hub, where a variety of operational and management issues were discussed.

Managers we spoke with were able to cite examples of instances where poor staff performance had been addressed effectively, using interventions ranging from speaking to the worker immediately or in supervision, to suspending a member of the team and issuing a verbal warning.

Multidisciplinary and inter-agency team work

The multidisciplinary team met once a week to focus on clinical issues. Complex case meetings occured once every two weeks. The minutes of each meeting were available to all staff.

Substance misuse services

Staff reported positive working relationships with partner agencies in their local area. The provider had strong links with Elmore Community Services and Aspire, both of whom operated services on behalf of Turning Point. The provider's dedicated safeguarding worker, based at the multi-agency safeguarding hub, had helped to forge healthy relationships with teams associated with that area of work such as the Police and social services.

The provider was working to strengthen links with local GPs by inviting them to each attend a team meeting. Staff we spoke with reported an aim of raising GP awareness of the range of services offered by Turning Point. Some members of the staff team divided their working week between one or more Turning Point hubs and GP surgery based 'shared care' services where ongoing treatment is supplied in the GP setting, with support from a specialist substance misuse worker.

The new dual diagnosis pathway for links between the provider and local mental health services was reportedly in the final stages of approval. The provider envisaged that the protocol wouldgreatly strengthen the relationship between the services and help to reduce potential risks associated with some clients by maximising the efficiency of the two-way referral process.

Good practice in applying the Mental Capacity Act

The provider's parent organisation has a core policy in place for the application of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (dated July 2015), which the Oxfordshire service has adopted. In addition to the main policy, a three page brief guide on mental capacity was available for use by staff.

Staff had access to eLearning on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Some of the staff we spoke with had completed the training module.

The provider obtained consent to treatment from each individual client. Workers did not conduct a capacity assessment with clients as a matter of course. There was no evidence of mental capacity assessments in the 14 care records we examined. That said, the evidence we saw suggested that clients generally had capacity, but that capacity might temporarily fluctuate based on use of substances and/or alcohol.

One member of staff we spoke with told us that if they had a concern, they would refer the case to the psychiatrist. According to the manager of the Oxford hub, the need to do this had not arisen recently.

We noted evidence that the topic of mental capacity had been discussed at team meetings.

Management of transition arrangements, referral and discharge

The provider had established strong working relationships with other partner agencies, such as housing providers, employment charities and their own national organisational network.

Are substance misuse services caring?

Kindness, dignity, respect and support

During our site visits, we witnessed numerous interactions between staff and clients. Staff consistently treated clients in an appropriate, respectful and supportive manner. There was a tangibly positive atmosphere around each hub.

Staff demonstrated an excellent attitude towards clients when interacting directly with them, and when talking about them with colleagues.

Clients we spoke with told us that staff were caring, compassionate, helpful, non-judgemental, supportive, understanding and responsive to their individual needs.

We collected a total of 52 comments cards from Oxford and Didcot. Patients wrote universally positive comments about staff. Their comments closely corresponded with statements made by clients we spoke with.

Clients we spoke with did not raise any concerns about staff maintaining their confidentiality. Staff we spoke with told us about a situation where a client had felt that their pharmacist had not respected their confidentiality. Staff supported the client to move to a new pharmacy.

The involvement of people in the care they receive

We examined the care records of 14 clients. Most care plans showed evidence of client involvement in the care planning process. One client told us that their keyworker had emailed a copy of their care plan to them, so that they could access it anytime and not lose it. Another client told

us that they did not have a copy of their care plan, but knew that it was kept in the hub office. However, a minority of clients we spoke with told us that they did not know what a care plan was.

Clients had access to local advocacy services.

Clients we spoke with told us that staff asked them if they wanted family or friends involved in their treatment program.

Clients were able to give feedback on the service they received, for example via regular client meetings and feedback boxes in the hubs. There were wall-mounted information posters which explain about how to give feedback and make complaints. There were also "You said, We did" boards, that highlighted how the service had been developed as a result of comments and suggestions received.

In January 2016, the first edition of a bi-monthly Client Newsletter was published. The newsletter was created by clients, for clients. The production team met once a fortnight at the Oxford hub. Edition one contained a range of information about groups and activities, the upcoming CQC visit, Refresh Café, along with some puzzles and a quiz.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Access and discharge

The service operated with no delay between referral, assessment and start of treatment. Where needed, assessments, prescription starts or medical reviews took place on the same day, or during the next working day.

The service operated a scheme that aimed to ensure a prompt response to the needs of people released from prison. The service received a total of 63 referrals for released prisoners during the three month period from November 2015 to January 2016 inclusive. The service assessed prisoners without delay when they made an unannounced visit to one of the offices and provided a bridging prescription (a prescription of methadone that is given whilst a person's care is being transferred between two services i.e. prison and a community-based service) where necessary, pending the start of a titration program (where the dosage of a substitute medicine (methodone), is adapted to suit the needs of the individual client, as they withdraw from the use of another substance (heroin)). The service conducted assessments under s12(2) and s14(2) of the Drugs Act 2005.

The service operated a comprehensive system for contacting clients who failed to attend appointments. Their re-engagement process was based upon a flow chart that indicated a specified total of five telephone calls or text messages to the client; followed by two telephone call to partner agencies; two engagement letters to the client; and, discussion of the case at team meetings. In addition, the provider operated a "prescription collection from service hub" arrangement used with clients with a history of being poor attenders. The facility centred around a written agreement completed jointly by the recovery worker and client.

There was a waiting list of approximately ten people for initial psychology assessments at the time of our visit. However, there was no waiting list for clients to be added to the psychology caseload.

The provider offered evening and weekend services such as prescribing clinics in selected locations, to meet the needs of clients.

Clients and staff we spoke with did not report any concerns about cancellation or late running of appointments.

The facilities promote recovery, comfort, dignity and confidentiality

The hubs had a range of rooms of different sizes, used flexibly for different purposes, such as individual consultations, group sessions and training events. Oxford hub was significantly larger and benefitted from having larger spaces that could be utilised for activity sessions such as boxercise and yoga classes. The organisation also used the Oxford hub as its training base for the whole area.

Interview rooms had adequate sound proofing to protect client confidentiality.

A wide variety of information was on offer for visitors to the hubs. There were posters and leaflets with themes that included mental health, Blood Borne Viruses, domestic abuse, dental services, safe injecting, complementary therapies, interpreting services, support groups and healthy eating. There were also DVDs available on a number of topics.

Substance misuse services

Meeting the needs of all people who use the service

The hub premises had appropriate adjustments made for people requiring disabled access, such as lifts between floor levels, disabled access toilets and a lack of steps within the premises.

The provider had arranged access to telephone based interpreting services, as required. Information leaflets were only available in English. The provider informed us that to date, there had been no demand for information in other languages, but stated that they would be responsive to any such future needs of their clients, should they arise.

Clients we spoke with told us that staff communicated with them using their preferred methods, such via emails or text messages.

The service responded well to the specific needs of clients. For example, the Oxford hub had a dedicated housing support worker, who provided support to homeless people in the city and there were specific interventions for victims of domestic abuse (the Freedom Group for female victims of domestic abuse met in secret, to best ensure the safety and confidentiality of attendees). However, some staff we spoke with acknowledged that extra work was needed to offer more support to people from black and minority ethnic backgrounds and the lesbian, gay, bisexual and transgender community.

The hubs had a supply of toys and books available for use by child visitors to the premises.

The hubs displayed information about a new website called "Wellbeing Cloud", launched by Turning Point in November 2015. According to the service, "Wellbeing Cloud is dedicated to promoting wellbeing and recovery from substance misuse. It includes lots of information about your local Oxfordshire service as well as some helpful online tools." The service also utilised web-based psychological interventions offered by Breaking Free Group.

In addition to its four hub locations, the staff provided regular satellite clinics in Bicester and Henley, along with an outreach service in smaller communities around Oxfordshire using "roaming recovery vehicles".

Listening to and learning from concerns and complaints

The provider told us that they received 13 complaints since April 2015, none of which were upheld.

Clients we spoke with told us that they knew how to complain. They told us that the provider was proactive in offering feedback. We observed records of two instances where the provider had appropriately responded to complaints made. The "You said, we did" boards displayed in hub offices illustrated that service development was shaped by complaints received. However, some members of staff we spoke with told us that they did not receive feedback on the outcome of investigations.

Are substance misuse services well-led?

Vision and values

Staff we spoke with were able to articulate a sense of the visions and values of Turning Point as an organisation. The Oxfordshire Operations Manager told us that staff had been shown a presentation on Turning Point's organisational values. The working practice of the multi-disciplinary team and individual hub teams clearly evidenced that the organisational values had been embedded into the day-to-day operation of the service.

Senior members of the organisation at both a regional and national level had visited the Oxfordshire service. Staff we spoke with were familiar with the senior management structure of the organisation.

Good governance

The provider operateed a comprehensive two-stage internal quality assurance system (stage one being self-assessment by the service and stage two being an audit from visiting member(s) of the parent organisation's quality assurance team) and a monthly review of client care records, to monitor completion and updating of risk assessments, care plans etc. However, the governance systems within the service had not served to address inconsistencies such as reviewing of risk assessments; notification of safeguarding concerns; variability of staff supervision frequencies; and, issues with the clinic room at the Oxford hub.

Managers we spoke with told us they felt they had sufficient authority to do their jobs; had sufficient administrative support; and, had an appropriate level of support from senior managers.

Substance misuse services

Leadership, morale and staff engagement

Staff we spoke with were very positive about the leadership and support offered by the management team for the Oxfordshire service. There was universal praise for the progress that had already been made during the provider's first year of their contractual term.

Staff we spoke with told us that there was a culture of openness within the staff team.

Some staff told us that a certain amount of tiredness and stress existed within the staff team, due to the demands of their work. However, all members of staff we spoke with displayed a high level of motivation for their work in helping to improve the lives of their clients. The high level of staff morale, job satisfaction and mutual support was clearly evident throughout the duration of our inspection site visit, in the way members of staff interacted with clients, each other and the inspection team.

Staff had the opportunity to give feedback on service delivery during regular team meetings and clinical governance meetings.

Commitment to quality improvement and innovation

The service participated in a yearly review into drug related deaths. The clinical lead in public health conducts a quarterly review into deaths connected with the service.

The service is currently assisting a local company with research into new clinical testing procedures.

The provider demonstrated its commitment to continually assist former clients via two significant initiatives. The peer mentor scheme aimed to train former clients who had successfully completed a program of treatment to work as volunteers to support current clients. The peer mentors helped to facilitate some of the group therapy sessions, supported by members of the permanent staff team. The peer mentors we spoke with were extremely positive about the opportunity that the scheme had given them to build their skills and their confidence levels, and to give back to the service that had helped them to make a positive change to their own lives. Refresh Café opened in January 2016 and was situated a short walk from the Oxford hub. It is a café operated as a social enterprise by Turning Point. It offered former clients the opportunity to gain work experience in a real business, offering their services to paying members of the public.

Outstanding practice and areas for improvement

Outstanding practice

- The service operated a peer mentor scheme and a social enterprise café to provide work-based experience for former clients and extra support to existing clients.
- A newsletter written by and for clients provided them with the opportunity to impact upon service delivery.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that they maintain accurate, complete and contemporaneous records in respect of each client.
- The provider should ensure that they maintain accurate stock records on clinical supplies and equipment, including details of deliveries received.
- The provider should ensure that the mandatory training identified is sufficient to support staff to carry out their roles safely and effectively.
- The provider should ensure that all equipment is properly serviced and maintained.
- The provider should ensure that they review all client risk assessments in line with their own stated target.
- The provider should ensure that needle exchange workers liaise with prescribers in cases where a client is continuing to use illicit drugs to supplement to their prescription.
- The provider should ensure that they provide appropriate feedback to all staff on the outcome of investigations into incidents, complaints and safeguarding alerts.
- The provider should ensure that they adequately assess and monitor the physical health of their clients.
- The provider should ensure that they provide an appropriate level of supervision support to every member of staff.