Turning Point Cheshire West and Chester

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

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:

- Clients were mostly positive about the service they received and the staff who provided. They felt safe within the service and knew how to raise concerns or make a complaint. A service user satisfaction survey was completed every two years. The most recent survey was carried out in December 2016, and the findings were mostly positive. Peer mentors and volunteers received training and support to work in the service.
- Clients had their physical health care needs assessed, and this information was used to inform their treatment, or shared with GPs and other agencies when necessary. A registered nurse was based at each site. They provided health promotion such as blood borne virus screening and hepatitis B vaccinations. There was a needle exchange service at each of the three sites.

Summary of findings

- Treatment was provided in accordance with Department of Health and National Institute for Health and Care Excellence guidelines. Clients had their needs assessed, and risk management and recovery plans implemented. They were offered psychosocial interventions, such as mindfulness and recovery groups. When necessary, clients were assessed for their suitability for an appropriate and safe detoxification programme.
- The service was nearing the end of the second stage of a three stage reconfiguration programme that changed the focus of the service from maintenance to recovery. Staff had received training to give them the skills to implement this new way of working.
- Staff received regular supervision, and most staff had completed their mandatory training.
- Staff had received safeguarding training, and knew what action to take if there was a safeguarding concern. Staff liaised with local authority safeguarding teams and other statutory agencies regarding child protection and domestic violence concerns.
- There was a young persons' team, which provided services to children and young people in local facilities such as schools and GP surgeries. A rural worker led clinics outside the three main sites, to promote access to clients who lived in remote areas.
- Incidents and complaints were reported, investigated, reviewed and followed up on appropriately.
- Prescriptions and medication were securely stored and managed.
- Turning Point had a framework and manual for the monitoring of quality and performance in substance misuse services. This had been effectively implemented at Turning Point Cheshire West and Chester. Key performance indicators were used to monitor the service, report to commissioners and benchmark the service against other substance misuse services.

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

- Over 60% of the service's clients with long-standing opiate dependency had been in treatment for over six years. This cohort of clients had an average length of treatment of over seven years, compared with the national average for this cohort of 4.9 years. The service was looking at new ways of working with this client group.
- Risk assessments and recovery plans were not always been completed as required.
- The service recorded clients' 'walk-in' visits, but did not monitor how this was implemented, or if the process delayed or deterred clients from accessing the service.
- Staff morale was uncertain, though many of the staff we spoke with were cautiously positive about the changes.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Refractive eye surgery		Start here...
Substance misuse services		See overall summary.

Summary of findings

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Turning Point Cheshire West and Chester

Services we looked at:
Substance misuse services

Summary of this inspection

Background to Turning Point Cheshire West and Chester

Turning Point Cheshire West and Chester provides alcohol and substance misuse services, in the Cheshire West and Chester area. It is based at three sites or hubs in Chester, Ellesmere Port and Northwich, and is commissioned by local authorities.

Turning Point Cheshire West and Chester provides community-based programmes for clients with alcohol or opiate dependence. This includes prescribing, psychosocial interventions, needle-exchange, an ambulatory detoxification programme in the service, and access to residential and inpatient detoxification elsewhere.

At the time of our inspection services were provided to 815 clients. Seventy seven percent of clients received support or treatment for opiate use and 16% for alcohol use. Over 60% of the clients who were receiving opiate substitute prescribing had been in treatment for over six years. Clients with an alcohol dependency followed a shorter but more intensive treatment programme.

The service registered with CQC to provide the regulated activity treatment of disease, disorder or injury on the 8 September 2016. However, it had been providing the service from the three hub sites since 1 February 2015, but they were registered as satellite services of one of Turning Point's residential rehabilitation services. The service had been provided by an NHS trust prior to Turning Point taking over the service in February 2015. Over 60% of clients receiving opiate substitute prescribing had been in the service for over 6 years, so had started treatment when the service was owned by a different provider.

Turning Point Cheshire West and Chester is one of over 80 registered services provided by Turning Point. Turning Point is a social enterprise that provides alcohol and substance misuse, mental health and learning disability services across England and Wales.

This is the first inspection of Turning Point Cheshire West and Chester.

Our inspection team

The team that inspected the service comprised: CQC inspector Rachael Davies (inspection lead), another CQC inspector and an assistant inspector.

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. This was an announced inspection.

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?

Summary of this inspection

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

During the inspection visit, the inspection team:

- visited the main site in Chester, both satellite services at Ellesmere Port and Northwich and looked at the quality of the physical environment
- met with 20 clients
- interviewed the registered manager and other managers
- met with 18 other staff members which including recovery workers, nurses and a doctor
- spoke with four peer mentors
- looked at 11 care and treatment records for clients
- examined how prescribing was managed in the service
- reviewed policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with 20 clients, either directly or in small groups.

Clients were positive about the service and the staff. They felt safe within the service, and told us that they found staff approachable for them to discuss their concerns. Clients were assessed, provided with information, and involved in their recovery programme. They were offered groups and activities. Clients who participated in groups and activities were generally positive about them. Clients were at various stages of their recovery, but were mostly positive about the support had received so far.

A service user satisfaction survey was carried out every two years. The most recent survey, from December 2016, showed that overall clients had been satisfied with the service they received.

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:

- All clients had a risk assessment and physical health check when they started using the service. Clients were offered blood borne virus screening. If clients were found to be hepatitis C positive they were referred directly to the local hepatology (liver) department. Hepatitis B vaccinations were offered and administered to clients.
- Staff had received safeguarding training, and knew what action to take if there was a safeguarding concern. Staff liaised with local authority safeguarding teams and other statutory agencies regarding child protection and domestic violence concerns.
- A limited range of medication was stored and administered directly by the service, but this was stored, managed and disposed of safely. Prescriptions were securely stored and managed.
- Incidents were reported, investigated, reviewed and followed up on appropriately.
- When necessary, clients were assessed for their suitability for an appropriate and safe detoxification programme.
- Recruitment checks were carried out before staff, peer mentors and volunteers started work in the service. Most staff had completed their mandatory training.
- Clinical waste was disposed of safely.

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

- A patient group direction for medication was past its review date.
- There was significant damp, reportedly of long-standing, on the wall of a kitchen used by staff and potential clients at the Northwich site.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

Summary of this inspection

- Clients had their needs assessed, and risk management and recovery plans implemented. Clients were offered psychosocial interventions, such as mindfulness and recovery groups. At the time of our inspection specific groups were planned for clients who had been in the service for over six years.
- Clients had their physical health care needs assessed, and this information was used to inform their treatment, or shared with GPs and other agencies when necessary. A registered nurse was based at each site.
- Treatment was provided in accordance with Department of Health and National Institute for Health and Care Excellence guidelines.
- There was a needle exchange on each site, where clients were offered advice and materials to make injecting safer for themselves and others. This included offering naloxone for emergency use in the event of an opiate overdose.
- The service was nearing the end of the second stage of a three stage reconfiguration programme that changed the focus of the service from maintenance to recovery. Staff had received training to give them the skills to implement this new way of working. Staff received regular supervision.
- Staff had working relationships with other agencies such as GPs, local hospitals, local authority safeguarding teams, and prison and probation services.

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

- Most staff had not had a recent appraisal.
- Limited care records were available from before February 2015. Risk assessments and recovery plans were not always been completed as required.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients were mostly positive about the service they received and the staff who provided. They felt safe within the service and knew how to raise concerns or make a complaint.
- The interactions we observed between staff and clients were positive and respectful.
- There were peer mentors and volunteers in the service. They were managed and supported by the peer mentor and volunteer manager, and completed training to take on the role. This included running self-management and recovery training groups for clients, and providing the needle exchange service.

Summary of this inspection

- A service user satisfaction survey was completed every two years. The most recent survey was carried out in December 2016, and the findings were mostly positive.

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

- The service user satisfaction survey had its lowest positive response rate in areas related to information about service user involvement.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The majority of clients self-referred to the service, and were seen promptly. Following assessment each client was assigned a key worker. There were care pathways for new clients coming into the service.
- Clients were able to 'walk-in' to the service without an appointment, after which they would be seen by staff or offered an appointment at another time.
- There was a young persons' team, which provided services to children and young people in local facilities such as schools and GP surgeries. A rural worker led clinics outside the three main sites, to promote access to clients who lived in remote areas.
- Services were accessible to people with restricted mobility.
- There was a needle exchange service at each of the three sites.
- Complaints were managed, investigated and responded to appropriately.

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

- Over 60% of the service's clients with long-standing opiate dependency had been in treatment for over six years. This cohort of clients had an average length of treatment of over seven years, compared with the national average for this cohort of 4.9 years. The service was looking at new ways of working with this client group.
- The service recorded clients' 'walk-in' visits, but did not monitor how this was implemented, or if the process delayed or deterred clients from accessing the service.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

Summary of this inspection

- Turning Point had a framework and manual for the monitoring of quality and performance in substance misuse services. This had been effectively implemented at Turning Point Cheshire West and Chester. This included key performance indicators and an audit cycle.
- Key performance indicators were used to monitor the service, report to commissioners and benchmark the service against other substance misuse services.
- Managers and leads from Turning Point Cheshire West and Chester met with staff in similar positions in the rest of the organisation, to share information and learning.
- An ambulatory detoxification programme was available as an alternative to inpatient or community detoxification, for suitable clients.

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

- Staff morale was uncertain, though many of the staff we spoke with were cautiously positive about the changes.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had an understanding of capacity and consent. Most staff were up to date with Mental Capacity Act and Deprivation of Liberty Safeguards awareness training. Just over half of the peer mentors and volunteers had had training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Clients were presumed to have the capacity to consent to their treatment programme. Staff told us that they had concerns about a client's capacity, they would discuss this within the team and a capacity assessment would be carried out. Clients had the various parts of the treatment programme explained to them, and were routinely asked to sign that they understood and agreed to participate in this. This included asking if they consent to information about them being shared with named relatives, and other professionals or organisations.

There were no clients subject to the Deprivation of Liberty Safeguards.

Refractive eye surgery

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

The three buildings that the service was provided from were leased from different organisations. The Chester building was owned by a local authority, the Ellesmere Port building by an NHS trust, and the Northwich building by a housing association.

Turning Point had standard policies and procedures for ensuring the health and safety of people using the building, but some of these were the responsibility of the owners of the building. The buildings were generally clean and well maintained and staff told us maintenance and repairs were usually carried out within a reasonable timeframe. The Northwich site was a large old building and as such had expected wear and tear in place. However, there was a very damp wall in a kitchen used by staff and mutual aid groups. Staff told us it had been like this for some time, following a leak from the drain outside, and had been reported to the owner of the building. The fire doors were in the process of being replaced during our inspection. Staff and clients reported that the Ellesmere Port building had been unbearably hot on the first day of our inspection, but engineers had attended and turned off the heating.

Clinical waste was disposed of appropriately. There were facilities for providing and disposing of client's individual sharps bins. There were sharps bins at all of the sites, and external clinical waste bins. The external clinical waste bins at the Chester site were not locked, but were stored in a locked car park within the building. The service had contracts for the disposal of clinical waste. There were separate toilets for clients to provide urine for testing. Nursing staff led on infection control and were responsible for cleaning in the clinic rooms. Routine checks of cleaning and equipment were carried out.

The clinic room on each site contained an emergency grab bag. This included adrenalin (for extreme allergic reactions), naloxone (for opiate overdose), syringes & needles, sharps bin, body fluid and blood spillage kit, gloves, and a mouth to mouth guard/mask.

In the event of a medical emergency, staff would call 999 for an ambulance. The service's policy for an emergency response did not include oxygen or an automated external defibrillator.

First aid boxes were available, in date, and routinely checked at each of the sites and there was first aid information on display.

Safe staffing

The service was based over three sites, covering six geographical areas, with a team manager managing three area teams each. Within each of the area teams there was a senior and two recovery workers. Across all the areas there was a psychosocial intervention lead, a rural recovery worker and a peer mentor coordinator, two support workers, and the young person manager and team. The operations manager, performance manager, and clinical lead (a consultant psychiatrist) worked across all the areas. There was a nurse based at each of the three sites, and a non-medical prescriber who was the lead for nursing.

The service had a full time consultant psychiatrist who was based in Chester but worked across the three sites. There were a further two doctors who worked two days each, one at Ellesmere Port and one at Northwich. The non-medical prescriber ran clinics across each of the three sites, and from satellite clinics from the hubs.

Up to 16 December 2016 the service had four vacancies. The service did not use agency staff, and cover for vacancies was provided from within the team. Some staff felt that there were not enough staff. Activities were not usually cancelled, but people who came to the service as a

'drop in' or 'walk-in', may have to wait or come back another time, as this aspect of the service was time consuming. Peer mentors were not used to provide cover for permanent members of staff.

Managers told us that they were in the process of reviewing caseloads to make them more balanced for individual staff. This was to reduce the number of clients who missed appointments and look at caseload segmentation. Caseload segmentation identified clients who were most at risk and who needed more intensive intervention. Up to 16 December 2016 the Chester hub had 362 clients, and saw an average of 73 clients per week, which was an average ratio of 34 clients to each member of staff. The Ellesmere Port hub had 272 clients, saw an average of 73 clients per week, which was an average ratio of 38 clients per worker. The Northwich hub had 224 clients, saw an average of 71 clients per week, and had a ratio of 43 clients per worker. These figures included clients in structured treatment only, and did not include staff with reduced caseloads because of part time hours or other roles, and did not include clients who saw more than one person. Some of the staff we spoke with had actual caseloads of over sixty clients.

The young person's service had 15 clients who accessed structured treatment, and staff saw an average of seven clients per week, with an average of seven clients per worker. This was in addition to other young people who were seen by the team.

The nursing staff had reduced caseloads to enable them to carry out their nursing role.

Up to 16 December 2016 the service had a sickness rate of 18.4%. Managers told us that there had been a recurrence of short-term sickness but this was being monitored and managed. At the time of our inspection there was one person on long term sick leave.

Up to 16 December 2016 all staff had completed all of their mandatory training. Staff told us that they had completed their training, and the training records confirmed that most staff were up to date with their mandatory training.

All staff, including peer mentors and volunteers, had recruitment checks carried out before they started working in the service. This included references and police checks.

Assessing and managing risk to clients and staff

We reviewed 11 care records.

All clients had an initial assessment which included risks and determined their suitability for groups. A full assessment was then carried out by the keyworker within two weeks of admission to the programme. The client would have a doctor's appointment at the time of the full assessment. The doctor would assess whether they required and were suitable for a detoxification programme or other treatment. The risk assessment was done at the initial referral and reviewed after the doctor's appointment. Nurses carried out physical health checks for new clients. All clients had regular prescription reviews.

There were three main groupwork pathways within the service. Following the initial referral clients were assessed. If clients used alcohol, their level of dependence was assessed using standardised tools, such as the alcohol use disorders identification test and severity of alcohol dependence questionnaire. The outcome of these tools, determined if a client was offered advice and information, or was assigned to a recovery worker or nurse led alcohol wellbeing group. Clients who used opiates or non-opiates may be invited to 'ambivalent to change' or 'moving forward' groups, before moving onto the 'introduction to change' group. Recovery skills and mindfulness groups were open to clients using alcohol or other substances.

If staff identified a healthcare concern, they would refer the person to their GP or a hospital for further investigation and treatment. Nurses carried out electrocardiograms (or heart scans), which were reviewed by the doctors. If a client had an electrocardiogram and the results were outside the expected range, this information would be shared with the client's GP.

Nurses carried out hepatitis C screening. If a client tested positive for hepatitis C, they would be referred directly to the hepatology department at the local hospital. The service was in the process of offering and administering hepatitis B vaccinations to its clients.

The service had a number of policies for safeguarding clients and their families which followed local authority guidance for managing safeguarding concerns. These policies included clear guidance and flow charts for the action that staff should take. This included in the event that a client disclosed, or staff suspected, there was abuse, domestic violence, or child sexual exploitation. Staff had contact details for local statutory and support organisations. Staff worked with other agencies such as

safeguarding, community mental health teams, probation and the local multi-agency risk assessment conference. The multi-agency risk assessment conference worked to protect children and reduce domestic violence.

Staff could identify potential safeguarding concerns, and knew how to report them. Training records showed that all but two staff out of 45 had completed safeguarding training, and 11 of the 12 volunteers or peer mentors had completed safeguarding training.

Where safeguarding concerns or issues were identified, these were incorporated into the client's risk assessment. An audit of safeguarding reporting had been carried out, and this found that the Ellesmere Port and Northwich sites were better at reporting than Chester. An action plan was implemented to address this. This included new corporate materials to support staff, and an overall safeguarding lead across the service. Reporting figures had since increased at the Chester site.

The prescribing and supply of prescriptions was managed and logged securely. This included recording when clients had collected prescriptions. If a prescription was required, staff filled in a prescription request form. A prescription was then generated by the prescription administrator for the doctor to sign. The keyworker then discussed the prescription with the client before giving it to them. The consultant psychiatrist told us that he sees most but not all of the clients he prescribed for, but discussed clients at regular weekly meetings. Prescribed medication was dispensed by community pharmacies across the Cheshire West and Chester area.

A limited range of medication was administered or provided onsite. Naloxone was offered to all opiate users, as it was used in the emergency treatment of opiate overdose. Nursing staff administered a high-potency vitamin B and C injection, which was used for clients detoxing from alcohol. Hepatitis B vaccinations were offered to clients and administered if required. Adrenalin was available on all sites in the event of an extreme allergic reaction.

Medication was securely and safely stored and managed. Medication fridge and clinic room temperatures were routinely checked. At the beginning of March a problem had been identified with the medication fridge at Chester. This was dealt with appropriately, the medication was disposed of and a new fridge provided. Medication was usually supplied and disposed of through Turning Point's national arrangements, but could be provided by a local pharmacy if required.

Turning Point had a patient group direction for hepatitis B vaccinations which was due for review in February 2017. This meant it was a few weeks overdue for review at time of inspection. High-potency vitamin injections were usually prescribed by the consultant psychiatrist or the non-medical prescriber. There was a checklist for nurses to complete when administering high-potency vitamin injections.

In addition to the three doctors, the service had a nurse who was a non-medical prescriber. Non-medical prescribers have the authority to prescribe any medication within their scope of knowledge, but in practice tend to prescribe within the clinical area they work in. The non-medical prescriber followed the Turning Point formulary or list of available medications, and these were all related to alcohol and substance misuse. The non-medical prescriber was supervised by the consultant psychiatrist.

The service had a lone working policy, which staff had signed to confirm they had read it. This was discussed in team meetings in March 2017.

Track record on safety

There had been no serious incidents at the service since it registered with the Care Quality Commission in September 2016.

Reporting incidents and learning from when things go wrong

Turning Point had an electronic reporting system for recording and reporting incidents. Staff knew what incidents to report and how to report them. Incidents were graded and reviewed by local managers, and within the wider organisation. Turning Point had organisation wide meetings to review and follow up on serious incidents and deaths.

Incidents were reported and investigated appropriately. Incidents were shared with the local clinical commissioning group's serious incident review group. For example: in February 2017 there had been two incidents relevant to this service discussed at the group. The service had submitted an initial 72 hour report to the group, which had then

decided if further investigation was required. On this occasion, the group had decided that there was sufficient detail and analysis in the investigation report so no further action was necessary. The second incident discussed, reviewed a more detailed root cause analysis report that the service had carried out.

Incident reports and action plans showed that investigation were carried out, which included a route cause analysis when required and that from these issues of good practice and areas for improvement were identified, and action plans developed and implemented. For example, following an incident it was identified that having a panel to decide on individual detoxification decisions had led to delays in providing the service. This process was reviewed and found to be service led, rather than meeting the needs of clients. This was changed, so it was now needs-led and decisions were made by the consultant psychiatrist.

There were no specific themes in the reporting of incidents. There was some verbal aggression towards staff and occasional pharmacy errors. The findings of incidents were discussed in team meetings and in supervision when necessary.

Duty of candour

The duty of candour is a requirement for providers to be open and transparent with people when things go wrong. The service had an up to date duty of candour policy and procedure. There had been no accident or incident at the service that met the criteria for duty of candour. Staff were open with clients about their care and treatment. Incident reporting showed that clients and where appropriate their relatives were provided with feedback following incidents.

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

Assessment of needs and planning of care

We looked at 11 care records.

There was an electronic records system for recording and storing clients' records. This was accessible by staff across each of the three sites.

Overall, the records were completed satisfactorily. Most clients had had an assessment, which included risk and their alcohol/drug use, from which a recovery plan was developed. Assessments included harm reduction and motivation to change. In some records, clients also rated themselves in various domains and this showed improvements during the course of their treatment. Assessments included the use of standardised tools such as the alcohol use disorders identification test and severity of alcohol dependence questionnaire. Clients were offered psychosocial interventions. Clients had a blood borne virus screen carried out, and were offered hepatitis B vaccinations where appropriate.

Risk assessments and recovery plans had not always been completed when required, though this was sometimes due to clients missing appointments, and they had been rescheduled. Staff followed up clients who missed appointments, and arranged welfare checks if they were unable to contact them and were concerned they were vulnerable.

However, there were limited records available from before February 2015, which applied to many of the clients who had been in the service for over six years. The service was taken over by Turning Point from an NHS trust in February 2015. Clients' records remained the property of the trust and were not transferred to Turning Point. The manager told us that they had six months after February 2015 to request any paper records they required from the trust, so they prioritised which records they required and managed the situation. As part of this they reviewed all the clients they were seeing at the time, and ensured they all had a recovery and risk management plan, and a compliance review. Older records, such as initial assessments, were not available.

In the event of a client's unexpected discharge from the service, there was evidence in the care records of discussions about support and crisis services.

Best practice in treatment and care

The service had reconfigured the service and increased the psychosocial interventions offered to clients. There was a psychosocial intervention lead who reviewed and oversaw groups within the service. Training had been carried out early in 2017, and the effectiveness of the programme was due to be carried out later in the year. Clients' evaluated groups after each session, and they carried out a psychometric evaluation at the beginning, middle and end

of each session. Clients completed the 'alcohol problems questionnaire' when they started and finished the alcohol programme which provided an outcome measure of their progress.

There were four main groups: introduction to change, recovery skills, a recovery-worker led alcohol management and recovery group and a nurse-led alcohol management group. The recovery skills group helped clients to develop recovery capital, identify the support they needed to achieve their goals, and develop life, communication and relationship skills. The recovery-worker led alcohol group was a psychosocial intervention based group, and focused on the reasons and behaviours that underlie client's addictions. The nurse-led alcohol group was health orientated, and was also attended by clients who were still drinking, and was part of the assessment and information giving pathway, leading up to a detoxification programme. Each client had a folder that was filled up each week with handouts, exercises and information leaflets from the groups they attend. The client kept the folder at the end of the treatment.

The young people's team used cognitive behaviour therapy worksheets, and motivational interviewing with children and young people.

A registered nurse was based at each of the three sites. They carried out healthcare screening assessments, blood borne virus monitoring, and hepatitis B vaccinations. They ran alcohol groups, particularly for clients who were still drinking as part of an assessment and preparation for a detoxification programme. The service monitored its use of these interventions, and the uptake had increased. The registered nurses carried out electrocardiograms, and these were reviewed by the doctor to determine if further treatment or a referral to healthcare services was required.

Turning Point had a psychosocial intervention lead who reviewed the provision of interventions across the organisation and their compliance with national guidance. The provider had completed a national audit of the implementation of the National Institute for Health and Care Excellence's clinical guideline 115: Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. This covered the 12 months up to 31 October 2016. The overall findings were that the service demonstrated good clinical practice but there were recommendations for improvements. The overall service was rated as satisfactory. Following this, changes had been made to the service to increase the provision of psychosocial interventions.

The provider had a prescribing policy for its drug and alcohol services. These referenced recognised national and best guidance for prescribing for alcohol, opiates and other drugs detoxification and withdrawal. Local and corporate policies reflected national guidance, which included "Drug misuse and dependence: UK guidelines on clinical management" by the Department of Health, commonly referred to as the 'orange book'.

Staff were trained to provide naloxone to clients and clients' relatives or friends. Naloxone can be used to delay the effects of opiate overdose whilst medical attention is sought. Staff provided information and guidance for clients on when and how to administer the medication.

There was a needle exchange at each site. This followed a harm minimisation approach, by making drug use safer for clients and those around them. This included a disposal bin for returned used needles, and unused sharps bins for clients to take away with them. Clients were encouraged to bring back their used sharps bins – if they did not bring one with them, they would only be given a maximum of two new needles to take away with them. Safety boxes for lockable storage of drugs and needles were available for clients with children at home. Clients who used steroids were given a laminated card with details of a website that gave information about steroid use. Staff offered clients foil (which was cleaner than domestic tin foil) and vitamin C and/or ascorbic acid tablets to use when preparing drugs. Clients were offered naloxone including training in its use. Condoms were also offered to clients.

Skilled staff to deliver care

The service's current workforce development plan was in three stages: induction that had taken place in November 2016, foundation had been implemented from December 2016 to March 2017, and the development stage that was due to take place from April to June 2017. This was part of the change of focus of the service from maintenance to recovery, and on giving staff the necessary skills and support to implement this.

Staff had completed training in the new ways of working. This included service specific training about alcohol and drug misuse, and about skills such as mindfulness,

facilitating groups and motivational interviewing. Nursing staff had received training to carry out electrocardiograms and administered hepatitis B vaccinations, and staff – including peer mentors – had had training to provide the needle exchange service.

The next steps included a segmentation exercise or review of caseloads and skills. From this, areas for staff skill's development and coaching were due to be identified and implemented.

Up to 16 December 2016, 100% of staff had regular supervision. Staff told us that they received regular supervision, both individually and in groups. Staff received individual supervision through their line manager. The psychosocial intervention lead provided group supervision.

The nursing staff received supervision from the non-medical prescriber who was also a nurse. The non-medical prescriber received supervision from the consultant psychiatrist.

The consultant psychiatrist had regular supervision with a clinical director within Turning Point. They were also part of the prescribing group within Turning Point.

Up to 16 December 2016 only 10 of 52 staff, or 19.2%, had had an appraisal. The service had identified this as an issue and implemented an action plan. The next phase of workforce development plan, which was due to be implemented from April to June 2017, included an assessment of staff skills and learning/coaching needs to work within the new structure.

Multidisciplinary and inter-agency team work

Care records included evidence of working with other agencies, which included GPs, prison and probation services and social services. The service had regular team meetings where clients were discussed. Specific issues included clinical risks and concerns, prescribing, and safeguarding.

Clients signed their agreement for information to be shared with other health professionals. We saw evidence of the service sharing information and working with clients and their GPs around their healthcare, and alcohol or drug related prescribing. Clients had a full physical examination when they joined the service and any concerns were shared with the client's GP.

The service had a rural worker who worked with GPs to identify clients living in rural areas with drug or alcohol problems.

Nurses had links with the hospital alcohol liaison team. They shared information about, and visited clients with concerns about alcohol or drug use.

Young people's service linked in with GPs, social services and child and adolescent mental health service. They received child safeguarding training through the local authority, and linked in with other local voluntary services, such as those that work with the victims of child exploitation.

Information about mutual aid sessions, such as alcoholics' anonymous and cocaine anonymous, were on display and provided to clients. Mutual aid sessions were not provided by Turning Point, but they took place at some of the sites.

Good practice in applying the MCA

There were no clients subject to the Deprivation of Liberty Safeguards.

Most staff had completed training about, and had an understanding of capacity and consent. Thirty-nine out of 45 staff, and seven out of 12 peer mentors and volunteers had completed Mental Capacity Act and Deprivation of Liberty Safeguards awareness training.

Clients were presumed to have the capacity to consent, so a capacity assessment was not routinely carried out. Staff told us that if they had concerns about a client's capacity, they would discuss it with the multidisciplinary team, and a capacity assessment would be carried out. The care records we reviewed showed discussion of consent, and signed consent documents. Clients were asked to sign their consent to various aspects of their treatment. This included sharing of information with other professionals and named relatives, and confidentiality agreements.

Equality and human rights

The service had an equality and human rights policy. Most staff (42 out of 45) had completed equality and diversity awareness training within the last two years. The provider's policies included an equality impact assessment.

Management of transition arrangements, referral and discharge

Substance misuse services

Most clients referred themselves to the service, and there were clear pathways for new clients who had problems with alcohol or substances. The service had a high proportion of clients who had been in services for over six years, and they were reviewing how they worked with this client group. The service had established links with local GP surgeries, hospitals, and inpatient/residential detoxification services. These were linked to each of the three sites. There were no shared care arrangements with GP practices. Prescribing was managed by the service and there were links with pharmacies in each area.

Are substance misuse services caring?

Kindness, dignity, respect and support

We spoke with 20 clients, either directly or in small groups. The clients we spoke with were mostly positive about the service they received and the staff who provided it. They found staff approachable, and said there was always someone to talk to. Clients said they felt safe within the service, and knew how to raise concerns or make a complaint. Clients were at various stages of their recovery, but were mostly positive about the support had received so far.

Clients were involved in their own recovery programme, and were given information about addiction, the substance/s they used and its effects. Clients had a physical health check when they came to the service. They were offered or attended group sessions and activities. Clients who attended sessions and activities were positive about them. They were not aware of sessions being cancelled.

The interactions we observed between staff and clients were positive and respectful. We did not observe any confidential information being shared with or about clients in public areas of the buildings.

The involvement of clients in the care they receive

A service user satisfaction survey was completed every two years. The most recent survey was carried out in December 2016 and had 117 respondents from across the three sites. The findings were mostly positive, with 75% to 91% of clients stating they agreed or strongly agreed that the service was accessible, provided them with information, gave them a say in decisions about their treatment, that they knew who their recover worker was, and that staff listened to them and gave them regular feedback and timely information about changes. The lower scores were that 48% of clients knew who the service user rep was, 52% were aware of the service user group, and 59% were encouraged to share ideas on how the service was run. Eighty-six percent of clients said they were involved in the development of their recovery plan, and 93% of clients were satisfied or very satisfied with the support and help they received. Ninety-three percent of clients were likely to recommend the service to friends and family.

There were service user groups in each of the three sites, which were led by the peer mentor and volunteer manager. There was a service user handbook which provided clients with information about the service, and how they could get involved in decision making. Clients had been involved in discussion about the provision of psychosocial interventions (groups and activities) within the service, and what they found helpful. Managers told us that clients had been part of interview panels in the past, but acknowledged that this did not happen consistently.

The service had peer mentors, who were people with experience of using drug or alcohol services. They received training to provide support to clients using the service. There were three courses a year for this service, and the peer mentors were usually in post for six months. They were encouraged to progress to becoming a volunteer afterwards. Peer mentors typically worked half a day a week. They did not usually work in the service where they had received their treatment. Their role included providing self-management and recovery training groups, called SMART groups. These were open groups, and were sometimes co-facilitated with the psychosocial intervention lead. Some of the peer mentors had completed training to provide the needle exchange service. This included giving clients information and materials to make drug taking safer for themselves and those around them. The service had a peer mentor and volunteer manager, who managed, supported and oversaw all the peer mentors and volunteers across the three sites. There were mechanisms in place to support peer mentors which included how to support and existing clients in the event of relapse.

The reception and waiting areas at all three sites contained lots of information for clients and a television. Information available included leaflets and posters about alcohol and

drugs, the support available at the service and at other services in the local area which included mutual aid. Suggestion boxes were in prominent areas at each of the sites.

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

Access and discharge

At the time of our inspection the service had 815 clients. There were 348 clients who received a service from the Chester hub, 256 clients at Ellesmere Port and 211 clients at Northwich. Seventy-seven percent of clients received support or treatment for opiate misuse, 16% for alcohol misuse, three percent for non-opiate drug misuse, and three percent for alcohol and non-opiate drugs.

Of the 815 clients using the service, 603 had referred themselves. The next largest referrers were statutory drug services who had made 58 referrals and GPs who had made 53. Clients were also referred from other organisations which included prison, probation and criminal justice services, hospitals and emergency departments, social services, and non-statutory drug and alcohol services.

The service had had 450 successful completions of treatment in the year up to the inspection. This included clients who were seen by the service prior to its current registration in September 2016.

Up to 16 December 2016, there had been 310 discharges from the Chester Hub, of which 156 were planned. Ellesmere Port hub had 295 discharges, of which 170 were planned. The Northwich hub had 179 discharges, of which 111 were planned. The young people's service had 40 discharges, 37 of which were planned. These referred to the most recent period of treatment, and excluded clients who declined to start treatment.

Over 60% of the service's clients with a opiate dependency had been in treatment for over six years. Managers acknowledged that this was higher than the national average. The average length of treatment for clients receiving opiate substitute prescribing at the service was over seven years, and the national average for this client group was 4.9 years. Managers told us these clients often found it difficult to engage with services in new ways of working. Some of these clients were very stable on their maintenance programme, and may therefore be understandably reluctant to change it. Other clients may be very chaotic in their substance use, and this may be why they needed ongoing support. The service was working with Turning Point's national psychology lead to develop ways of working effectively with this group of clients. This included segmenting caseloads to prioritise working with clients who had received the service for over six years.

All three hubs offered a 'walk-in' service. This allowed clients to visit the service without an appointment. Staff and clients gave mixed views of the availability of staff to see clients who accessed the service in this way and the level of initial support they were able to provide for them. All contacts (scheduled or walk-ins) were recorded on the daily contact sheet at each site, and these were logged on the electronic records system. However: the information was not collated and analysed, so the service could not provide information on how many walk-ins there were, how many had been asked to wait or return another day, and how many of these had missed subsequent appointments. Managers told us that as part of the caseload segmentation, they were reviewing the duty and walk-in appointment system, so that it was more responsive and easier to manager.

Managers told us that the service was commissioned to provide support for clients using new psychoactive substances (formerly commonly known as 'legal highs'), but they had few clients referred to them for support with this.

The facilities promote recovery, comfort, dignity and confidentiality

Clients had access to their local service based in one of the hub buildings Chester, Ellesmere Port or Northwich. The type of building and layout was different at each site, but all had reception and waiting areas, interview and groups rooms. Each site had an acupuncture room, a needle exchange, a clinic room for physical healthcare checks, and specific toilets and facilities for providing urine samples.

There was a weekly therapy and activity programme for each of the three hubs. This included groups that were a specific part of the pathway, such as introduction to change, recovery skills, and recovery worker/nurse led alcohol sessions. There were other groups that supported clients such as mindfulness, acupuncture and a guitar club.

Substance misuse services

There was a needle exchange at each site, where clients were provided with harm-minimisation information and materials.

Meeting the needs of all clients

All three sites were accessible to people with restricted mobility, and had accessible toilet facilities.

Turning Point provided information in multiple languages, but staff acknowledged that this wasn't always easy to access. Staff and managers told us that most clients spoke English, but that a telephone interpreting service was available if required. Staff told us that documents could be translated if required. At the Ellesmere Port site there were leaflets available in Polish. One of the staff spoke Polish if this was required, but an interpreter would be accessed if needed.

There was a young persons' team, which included a lead, a recovery worker and a part time support worker. They visited children in local facilities such as schools and GP surgeries, so that children did not come to the main sites where adult clients were seen. The teams linked in with GPs, social services and child and adolescent mental health teams as necessary.

Clients with alcohol or substance misuse problems living in rural parts of the Cheshire West area were not always motivated or able to come to the main sites in the towns. The service had a rural worker who ran clinics outside the main urban areas, to encourage engagement with clients in rural areas.

Listening to and learning from concerns and complaints

In the year up to 16 December 2016 the service had received 21 formal and informal complaints. Of these 10 formal complaints were upheld. There were no complaints referred to or upheld by the Ombudsman.

Turning Point had a complaints policy, which included targets for responding to and investigating complaints. Clients could complain directly to their local service, or corporately to Turning Point. All complaints were discussed in clinical governance meetings and were reported corporately. If necessary an independent member of staff would be appointed to investigate and respond to the complaint. This member of staff was a team leader or above. The person making the complaint was provided with a response to their complaint, and details of any changes or learning that the service had made from this.

Staff were aware of the complaints process. Information about how to complain was on display. The clients we spoke with said they knew how to raise concerns.

There were no significant themes. Managers told us that there had been a number of recent complaints that related to changes to the service. For example; clients, families and stakeholders not being clear about what to expect from the service, or having different expectations of it.

Are substance misuse services well-led?

Vision and values

Turning Point is a social enterprise and states that its focus is on "improving lives and communities". Turning Point's vision and values were on display. Managers told us that these had been reviewed corporately to include learning disability services, which Turning Point provided nationally in addition to alcohol and substance misuse and mental health services. These included driving improvement, communication with staff, financial stability, potential to grow, treating individuals as individuals, and to be innovative. The service had a folder of polices that incorporated Turning Point's values, and staff had signed these to confirm that they had read them.

Good governance

The provider had an integrated governance framework. There was a clinical governance manual for the substance misuse service. This described how information about the quality and performance of the service was used and shared with the other substance misuse services, and ultimately within the wider organisation.

There was a weekly clinical risk meeting at each of the sites. This included a discussion of all clients, and a standard agenda for other issues which included health and safety, staffing, the group programme, and policies and guidance.

The provider's risk register was primarily focussed on general business concerns, and did not included specific service or client risks.

Substance misuse services

The service had an audit and review calendar. This included monthly sampling of caseload audits and six monthly full staff file audits. Other monitoring included an annual observation of practice audit, audits of prescriptions and National Institute for Health and Care Excellence guidance implementation. An annual review of the service was carried out by Turning Point staff who did not work in this service. This was last carried out in November 2016. It was detailed, and covered the five key questions or domains used in Care Quality Commission inspections. From this an action plan for the service was developed, which included all the routine activities that the service needed to complete. This included one-off audits, regular supervision, caseload reviews, and specific incidents.

The service routinely compiled and analysed information about its key performance indications. These were extensive and included waiting times and successful completions of treatments, audits, and national treatment outcome profile information. This information was used to report monthly to commissioners of the service, internally in comparison with other Turning Point services, and through national treatment outcome profile reporting and benchmarking. The manager was knowledgeable about the information used in the key performance indicators, and could explain the reason behind dips or changes in the information, and how this had been used to influence changes. For example, the percentage of new clients who were offered hepatitis B vaccinations had dropped compared with previous months. This was due to there being fewer clients who were appropriate. Planned exits from treatment were usually 100% for the young persons' service. However, as there were only small numbers of clients using this service (currently 15), if one client unexpectedly left the service it would affect this percentage disproportionately. Staff told us they received weekly emails which included performance information about the service and audits.

Local leads met regularly with staff in similar positions across Turning Point, to share learning and good practice. For example; the young person's led met monthly with other managers, and the non-medical prescriber attended national prescribing meetings, and national groups specifically for non-medical prescribers.

The provider had a regular mortality and morbidity review meeting where any deaths across the whole of Turning Point (including non-drug and alcohol services) were reviewed. This included any deaths of clients who used this service. For each client who had died, the service presented a summary of the circumstances, any recommendations or areas of positive practice. These did not indicate that the cause of death was attributable to or preventable by the service, but identified areas where improvements in care could have been made. This included recommendations for more timely medical reviews, and processes for following up if clients did not attend appointments.

Leadership, morale and staff engagement

Staff had mixed views about the changes to the service, and their impact on staff morale. Turning Point had taken over the service from an NHS trust in February 2015, and the view of many staff was that this had been a difficult transition which had negatively impacted on staff who had been transferred over to the new company. The recent restructuring of the service to move away from established ways of working was also challenging for staff. However, most staff were cautiously positive about the direction of the changes and felt that overall morale was improving. Pressure on staff from the volume of clients, and problems with technology were perceived by staff as compounding their workload.

There had been several changes in manager, due to the change of service and individuals leaving. The service had a registered manager and a new manager had started five weeks before the inspection. The new structure included team leaders with specific roles. Staff were generally positive about the new management arrangements and leadership and felt that managers were approachable.

Managers acknowledged that the leadership team at the service was still relatively new, but that they felt supported in their roles. They had been involved in the developed of leadership competencies, which were due to be reviewed with managers in June 2017. These focussed on skills leaders needed to work effectively within the organisation, and what support they needed to develop these.

Commitment to quality improvement and innovation

An ambulatory detox was provided by registered nurses from each of the service's three sites. This was where clients visited the service to take detoxification medication and be monitored by nursing staff, and then returned home supported by a friend or relative. This was an alternative to community-based or inpatient detoxification programmes.

Substance misuse services

Prior to any detoxification regime, clients attended a seven-week alcohol group, during which the nurses provided information and assessed each client's motivation and physical health. Clients were offered a detoxification programme at the end of the seven-week group. This was usually in an inpatient service, but if clients met the criteria they were offered ambulatory detox. Clients with a serious illnesses or a history of seizures would not be offered ambulatory detox. The final decision as to whether they were suitable was made by the consultant psychiatrist. Prior to an ambulatory detoxification starting, the client's physical health would be monitored, and high dose vitamins would be administered. Client's collected the detoxification medication from specific pharmacies in each area, and brought it to the service to take. The detoxification programme took place over several days, and clients were monitored physically and by assessment tools and rating scales throughout the process. The client needed to have a person with them at home at all time during the detoxification process, and the process was explained to the person, any concerning symptoms they should observe for, and how to contact help if this is required. The supporting person signed their agreement with this process.

The service had an audit cycle led by the consultant psychiatrist. An audit of alcohol services had been carried out. The findings of this had been satisfactory, but the audit highlighted that improvements were required as the paperwork was disorganised. A standardised assessment had been implemented across all the nurse-led alcohol groups. Future audits that were planned as part of the cycle included the use of naloxone, consistency of diagnosis, and the use of safety boxes.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that clients who have been in the service for an extended period of time have their needs and care plans regularly reviewed.
- The provider should ensure that all clients have a current risk assessment and recovery plan.
- The provider should ensure that all patient group directions for medication are reviewed within the specified timeframe.
- The provider should ensure that all staff have a regular appraisal or assessment of their training and development needs.