Phoenix Futures Sheffield Residential Service

Quality Report

229 Graham Road
Sheffield
S10 3GS
Tel: 0114 230 8230
Website: www.phoenix-futures.org.uk

Date of inspection visit: 12 and 13 November 2018
Date of publication: 18/01/2019

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

Summary of findings

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

Overall summary

We rated Phoenix Futures Residential Service as good because:

- Staff carried out regular checks to maintain the safety of the environment. Males and females had separate sleeping areas and clients told us they felt safe in the service.
- Staff had achieved high levels of compliance with their mandatory training and were knowledgeable about safeguarding procedures. They reported incidents and learned from things when they went wrong.
- Client care plans were holistic and contained clear goals linked to clients outcomes.
- Staff were well trained and received regular supervision and appraisal.
- Staff treated clients with care and compassion. They understood their needs and involved them in decisions about their care and about how the service was run. Clients could give feedback and make suggestions for improvement.
- Staff involved families and kept them informed about how treatment was progressing where clients wanted them to.
- The service had clear admissions criteria and robust care pathways including access to move-on accommodation.
- Clients had access to activities and could develop work skills and gain vocational qualifications
- The service had strong leaders who were experienced and knowledgeable in addictions. Staff were proud to work for the provider and thought the culture was open and transparent with approachable visible managers.
- The provider had improved governance arrangements and provided managers with access to more performance management data. Oversight of training had improved. Care records systems and incident reporting systems were electronic and accessible to all staff.
- Staff met with each other to share and improve practice. They reviewed service improvement plans and implemented the actions necessary to improve services.

However:

- The defibrillator was kept in a locked area which went against national guidance.
- Client crisis plans did not contain contact details for the local crisis service.
- The provider did not have oversight of compliance rates for staff engagement with supervision.
- The service did not have any formal mechanisms to obtain feedback from carers
- Not all clients were given a timescale for a response when their needs could not be met straight away.
- Some clients said there was not enough variety of food on offer at meal times.
- Service improvement plans did not always specify accurate review dates and we could not identify where higher managers had reviewed actions.

Summary of findings

Contents

Good

Phoenix Futures Sheffield Residential Service

Services we looked at:
Substance misuse/detoxification.

Summary of this inspection

Background to Phoenix Futures Sheffield Residential Service

Phoenix Futures Sheffield residential service provides a detoxification and rehabilitation service for people who are recovering from drug and/or alcohol misuse. It is part of a wider provider organisation called Phoenix Futures which is a registered charity. The service accepts national referrals and privately funded clients. It was registered with the Care Quality Commission on 20 January 2011. It is registered for the regulated activity 'accommodation for persons who require treatment for substance misuse'. The service had a registered manager in place at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service is not required to have a controlled drugs accountable officer in place even though staff may store and administer controlled drugs.

The service accepts both men and women can accommodate a maximum of 36 adults. At the time of our inspection there were 27 people using the service, 21 males and six females. The premises are in a large Victorian house, a short bus ride from Sheffield city centre. It is set in its own grounds and consists of one main house and a smaller separate annexe building on the same site. The service provides abstinence based treatment based on a therapeutic community model. On average, clients stay there between 3 and 6 months but this can be longer or shorter depending on individual need and circumstances.The treatment consists of a groupwork programme with talking therapies and complementary therapies. In appropriate cases, the service can provide clients with a medically monitored detoxification from drugs or alcohol. This is carried out by a specialist GP who works under a contract with the service.

At our last inspection of May 2017, we identified one breach of regulation under the Health and Social Care Act 2008 (Regulated Activities), Regulations 2014. The service was not rated but we issued one requirement notice in relation to Regulation 17: Good governance. Following that inspection, the provider submitted an action plan setting out the steps they would take to address these breaches. At this inspection, we found the provider had met the requirements of regulation 17 and achieved a rating of good overall.

Our inspection team

The team that inspected the service comprised of the team leader and one specialist adviser who was a nurse. The team also contained one assistant inspector and one inspector who were shadowing for one day each and one second inspector who was there for one of the days.

Why we carried out this inspection

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

Summary of this inspection

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information and sought feedback from staff at one focus group.

During the inspection visit, the inspection team:

- Visited the site, looked at the quality of the environment and observed how staff were caring for clients;
- spoke with seven clients who were using the service;
- spoke with three carers of clients who were using the service;
- spoke with the registered manager, the programme manager and senior managers;
- spoke with nine other staff members; including therapy workers, doctors and a nurse;
- obtained feedback from four service commissioners;
- attended and observed one hand-over meeting and one therapy group;
- looked at five care and treatment records of clients;
- carried out a specific check of the medication management;
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Clients told us that staff were caring, committed and respectful when delivering care. They were mindful in considering confidentiality when speaking with families and carers. They told us staff involved them in their care plans including discharge plans and assisted them to keep in touch with their families. They said they found the structure and the regime tough at times but they acknowledged the structure had helped them turn their lives around. Clients welcomed the new physical activity programme and they valued the group therapy and written work. However, most clients said the environment needed refurbishment and there was not always enough variety of food on offer at meal times.

All the carers we spoke with had positive experiences to share. They praised the staff for their dedication and commitment to helping clients with their addiction. They said staff were approachable and they were visible in the service when they needed assistance. They thought staff genuinely cared about the well-being of their loved one and supported them meaningfully by engaging them in activities and therapy. Staff kept carers involved and they could contact the service and speak with staff or their relative when needed. Carers said they had not been given specific information about how to complain but they said they would feel confident to approach the key worker with any concerns.

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?

Good

We rated safe as good because:

- Staff carried out regular checks to maintain the safety of the environment. This included fire safety and electrical testing and emergency equipment such as the automated external defibrillator.
- The provider had implemented separate sleeping areas for males and females and clients told us they felt safe in the service.
- The provider had implemented a training matrix for all levels of staff and improved compliance rates with mandatory training. This was something we told them they must address following our last inspection in July 2017.
- All clients had a comprehensive risk assessment which staff updated in response to concerns and changing risk levels.
- All staff had been trained in safeguarding and knew how to raise safeguarding concerns. They reported all incidents using a new electronic reporting system. Staff made improvements and learned lessons from incidents.

However:

- The defibrillator was kept in a locked area which went against guidance provide by the Resuscitation Council UK.
- Client crisis plans did not contain contact details for the local crisis service.

Are services effective?

Good

We rated effective as good because:

- Client recovery plans were holistic and contained clear goals linked to the provider's outcome monitoring tool. Staff developed specific plans with clients at risk from unplanned treatment exit.
- Medical staff prescribed pharmacological interventions in line with guidance provided by the National Institute for Health and Care Excellence, (NICE). Prescribing protocols had been agreed between the provider and the doctors working with the service.
- Staff had access to additional training and some had specialist substance misuse qualifications. Managers supervised staff regularly and carried out an appraisal each year.
- All staff had been trained in the requirements of the Mental Capacity Act and the Deprivation of Liberty Safeguards and the provider had an up-to-date policy and procedure in place.

Summary of this inspection

However:

- The provider did not have oversight of compliance rates for staff engagement in supervision.

Are services caring?

Good

We rated caring as good because:

- Staff treated clients with care and compassion. They understood their needs and supported them to achieve their individual goals. Staff maintained client privacy and confidentiality.
- Staff involved clients in care planning and risk management planning. They involved clients in decisions about the service and enabled them to give feedback through surveys, forums and suggestion boxes.
- Staff involved families and carers appropriately. They kept families informed where appropriate and provided them with support when they visited the service.

However:

- The service did not have any formal mechanisms to obtain feedback from carers about the service.

Are services responsive?

Good

We rated responsive as good because:

- The service had clear admission criteria and robust care pathways in place for clients whose needs could not be met by the service. This included move-on accommodation on completion of the programme.
- Clients had discharge plans in place including plans for unplanned exit from treatment. Staff liaised well with care managers and care coordinators when clients were discharged or transferred.
- Staff encouraged clients to become active and engage with the local community. Clients had access to develop real work skills and gain vocational qualifications.
- Clients could raise concerns through service user meetings and had access to a formal complaints process. Staff responded to complaints quickly and appropriately.

However:

- Not all clients were given a timescale for a response where their needs could not be met straight away.
- Some clients said there was not enough variety of food on offer at meal times.

Summary of this inspection

Are services well-led?

Good

We rated well-led as good because:

- The service had strong leadership with staff who were experienced and knowledgeable in the field of addictions. Senior leaders were visible and visited the service regularly.
- Staff felt proud to work for the organisation. They felt valued and respected and could raise concerns without fear of retribution.
- Overall governance arrangements had improved. Staff carried out audits, developed action plans and monitored the impact of changes. The provider had improved medicines management and staff compliance with mandatory training. They had improved incident reporting procedures and systems to store client care records.
- The provider had a recognised quality assurance system in place and provided managers with access to some key performance data to help them improve services.
- Staff were committed to continuous learning and met regularly to share and develop good practice.

However:

- The timescales for service improvement plan reviews were not always clear and we could not identify whether higher managers had reviewed the key actions to check they had been achieved.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff had completed the Care Certificate which included a module covering mental capacity. In addition, 100% of staff had completed further on-line training in the Mental Capacity Act which, included training in the Deprivation of Liberty Safeguards. The provider had an up-to-date policy on the application of the Mental Capacity Act and Deprivation of Liberty Safeguards which staff were aware of.

The staff we spoke with demonstrated an awareness of the principles of the Act and the need to assess clients' capacity on an on-going basis. Staff told us where they had concerns, they would seek advice from local or higher managers. Staff could seek advice from the nurse employed at the service or the clinical quality manager who worked at head office. Staff showed an understanding of the concepts of unwise decision making and best interest decisions and they could give us examples.

Staff demonstrated an understanding of the Deprivation of Liberty safeguards and told us if a client wanted to leave they would not be able to stop them from doing so, though they would always try to assist clients to discharge themselves in a more planned way if that was their final decision.

Good

Substance misuse/detoxification

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

Are substance misuse/detoxification services safe?

Good

Safe and clean environment

Clients and staff undertook cleaning duties in all client areas of the house including bedrooms, communal kitchens, bathrooms and lounge areas. Each morning, staff and clients carried out cleaning and maintenance duties according to a rota overseen by a member of staff. Most areas of the house were clean but we found one office which clients sometimes used to make phone calls was not as clean as it should have been. When we pointed this out to staff, they made sure it was cleaned immediately and added the room to the cleaning rota. Most of the clients and staff we spoke with told us the house needed refurbishment. Staff had redecorated the dining room in the previous 12 months but some of the paintwork and wall paper in the rest of the house was chipped and scuffed. The furniture in client bedrooms and communal areas had signs of wear and tear. Most of the clients we spoke with told us the house did not feel homely due to the poor state of the decoration and furnishings. We spoke with the provider's director of operations who told us the organisation had plans to refurbish the building over the following 12 -18 months. We saw plans to replace furnishings in communal areas and client bedrooms such as curtains and bed mattresses before March 2019. The provider had commissioned a company to carry out further refurbishment beyond March 2019 and this included redecoration to client bedrooms, communal areas and corridors.

Staff and clients had access to handwashing facilities including non-alcohol hand cleansers in some communal areas. We saw posters next to hand basins advising people of correct hand-washing techniques. Staff had appropriate arrangements in place to manage and dispose of clinical waste. The provider had an up-to-date health and safety policy in place including a fire risk assessment. We looked at these documents as part of our on-site inspection. Staff carried out regular checks to maintain safety including firefighting equipment and electrical testing Staff checked first aid boxes but we found one out-of-date bandage in one of the boxes.

Clients had access to a well-equipped clinic room with weighing scales, a height measure, a blood pressure monitor and a drug which could be administered in the event of an overdose of opiate drugs, for example, heroin. Staff had access to an automated external defibrillator and they had been trained to use it. However, we found staff had placed the defibrillator in the clinic room which was locked when not in use. Guidance from the Resuscitation Council UK, recommends that defibrillators should be placed in an openly accessible area to allow immediate access in an emergency. Following the inspection, the provider confirmed they had moved the defibrillator temporarily to the staff office with a view to having it fitted on the wall in the main foyer.

The provider had implemented separate sleeping areas for male and female clients. Female clients slept in a separate annexe which they controlled access to with a key fob. Where the provider admitted more female clients than could be accommodated in the annexe, staff could place females on one of the floors in the main house which had been designated as a female only area. The provider told us about these arrangements at out last focussed

inspection in July 2017 but they had not implemented an appropriate access system to prevent males from accessing the area. At this inspection, we found the provider had implemented a key fob system so female clients could exclude male residents entering female bedrooms and bathrooms. At the time of our inspection, all the female clients were accommodated in the annexe. Female clients told they felt safe living in the facility.

The service had an up-to-date ligature risk audit which was held electronically and in the main staff office. The audit was comprehensive and contained actions to mitigate risk. The house contained many potential ligature points both in client bedrooms and communal areas. Staff mitigated these risks using several measures including strict referral criteria which excluded individuals thought to be at high risk from suicide. Staff sought advice from the client's GP and other relevant professionals appropriately to assess risk. Access to client bedrooms and bathrooms on the second floor of the house was restricted during the day whilst clients engaged in the programme structure. Staff controlled access to these areas via a fob system. Clients had their own fob but handed these in during the day. The provider had a policy which advised staff about actions to take where a client was at risk of self-harming. We checked the care record of a client who had been at risk of self-harm and saw that the file contained a safety plan and other measures consistent with the service policy.

Safe staffing

The provider had 13 full time staff and access to a bank of staff employed by Phoenix Futures to cover staff absences such as leave, sickness and vacant posts. In the period July 2017 to August 2018, the provider covered 263 shifts using bank staff. They did not use agency staff and, in the same period, they had no shifts that had not been filled by bank staff. At the time of our inspection, there was one vacancy for a part-time nurse and one therapy worker vacancy. During weekday shifts, the service had a three staff on duty from 9am until 5pm and one staff from 10am until 10pm. In addition, the registered manager, the programme manager and two administration staff were also on-site from 9am until 5pm. At weekends, there was one member of staff on from 9am until 5pm and one from 10am until 10pm. Clients told us that staff were generally available but sometimes there could be shortages at times when a lot of clients needed escorting to individual appointments away from the premises. Managers ensured there was a crossover of staff on the morning shift so more staff would be available at busy times to administer medication. Managers told us they could predict when busy times were likely to occur because admissions to the service were always planned and family visits were scheduled in advance. They told us they had the flexibility to increase or decrease staffing levels depending on client numbers. Bank staff would be offered additional shifts at the weekend if there was a need. For example, two weeks prior to our inspection, the manager had increased staffing at the weekend because clients had several family visits to the service arranged. After 10pm, the provider had one member of staff who slept on the premises and there were appropriate lone working arrangements in place. The staff member always had access to an on-call manager at night who could attend the premises within 40 minutes or less of being summoned. The on-call manager also had access to an on-call senior manager available as required. Managers at the service told us they rarely had to attend the service at night and could give guidance to staff over the phone if needed. Staff told us they felt safe being alone at night in the service and that managers responded quickly when needed.

Staff had a training matrix tailored to their role and function within the team. Each staff member had a training log which managers used to identify training needs and monitor compliance. This was something we told the provider they must address following our last inspection in July 2017. As part of this inspection, we examined five staff personnel files containing records of training. Staff told us they were up-to-date with their mandatory training and we could see evidence of dates of training and completion certificates in staff files. Mandatory training requirements consisted of the following courses; Care Certificate, data protection, child and adult safeguarding, fire safety, emergency first aid at work including how to operate the automated external defibrillator, Naloxone, drug and alcohol withdrawal scales, medicines administration, Mental Capacity Act and Deprivation of Liberty Safeguards, case management and incident reporting. Following the inspection, managers supplied data to show that overall, the compliance rate for mandatory training was 96%. The Care Certificate, data protection, safeguarding and the drug and alcohol withdrawal training and Mental Capacity Act training showed a compliance rate of 100%. Care certificate training consisted of 15 modules as follows: Understand your role, personal development,duty of care, equality and

diversity, work in a person-centred way, communication,privacy and dignity, fluids and nutrition, awareness of mental health, dementia and learning disability, safeguarding adults, safeguarding children, basic life support, health and safety, handling information,infection prevention and control. The provider's lone working risk assessment stated that staff should have training in managing challenging behaviour and, although staff had undertaken this training, it was not included in the provider's mandatory training requirements. This could mean that some staff who required this training might be missed.

Some clients told us staff did not have enough training to support clients with mental health issues but we found some staff had participated in additional mental health awareness and suicide awareness training. The provider told us that managers would identify during the induction period which staff required additional mental health awareness training and organise it as required. Some staff came to the service already with an awareness of mental health issues. Following the inspection, the provider told us that 100% of the current staff team had completed mental health awareness training in addition to their care certificate training. Usually, staff could seek advice from the mental health nurse employed full-time across the residential and family service but the post was vacant when we inspected the service. The provider employed a mental health nurse at their head office in a clinical lead role. The clinical lead regularly visited the service and could provide advice to staff as needed. Staff were actively recruiting for the nurse post and, in the interim, had an agency nurse who was due to start work at the service on 26 November 2017.

Assessing and managing risk to patients and staff

All clients had a comprehensive risk assessment carried out by staff on entry to the service. This was in addition to pre-admission risk screen where staff identified risk factors from referrers and care coordinators. Where possible, staff carried out face to face risk assessments and where this was not possible, they carried out telephone interviews with clients. Staff gathered relevant information from the client's care coordinator and GP prior to admission so they were aware of any specific mental or physical health risks. The service had admissions criteria in place and would refuse admission to clients where they felt staff could not manage the risks involved. For example, we saw how staff declined an admission due to the client having a history of offences which they thought could pose a risk to other clients. As part of the risk assessment process, staff assessed client motivation and willingness to cooperate with the rules of the community. This meant clients who were admitted had a strong desire to remain drug free and a willingness to abide by the rules of the therapeutic community. Staff explained that they could not support clients with high risk behaviours because they did not observe clients in a formal way. Staff expected all clients to engage in the therapy programme during the day and staff would notice if they were missing. However, at night, staff did not carry out regular checks on clients. All clients shared bedrooms with at least one other client and some rooms had up to three clients sharing. Clients had roles and responsibilities within the therapeutic community which meant they could support each other.

Since the last inspection in July 2017, the service had implemented electronic records to record most aspects of client care. As part of our inspection, we examined five care records and found all of them to contain an up-to-date risk assessment and a crisis plan. In addition to crisis plans, the service had introduced an unplanned discharge process. This was completed with the client and their care coordinator prior to admission to ensure safety arrangements, such as travel and accommodation, were in place in the event the client left the service suddenly. Client crisis plans were personalised but none contained the number of the local crisis team even though there was a space for the contact number on the plan. We saw examples of client involvement in relation to risk assessment planning for home leave. Staff updated client risk assessments every 12 weeks or when needed in response to identified or escalating risks. We saw evidence that staff updated risk assessment and management plans in response to incidents. For example, during our observation of the morning handover meeting, we saw how the manager ensured staff updated the risk management plan for a client who had been taken to hospital the previous night in relation to a physical health problem. There was one main handover meeting each morning but the service had handover arrangements in place for the start of each shift where staff coming onto shift met with the manager or a staff member from the previous shift. When we examined care records, we saw examples of harm

minimisation and safety planning in place. For example, clients could be issued with take home doses of medication including overdose prevention medication where appropriate in the event of unplanned discharge.

Staff did not use restrictive interventions and never carried out any sort of physical restraint with clients. Staff participated in training aimed at helping them verbally de-escalate any aggression from or between clients. Staff told us aggressive incidents were very rare and they felt confident to deal with such behaviour. The service had protocols in place for police involvement and searching. Staff were not allowed to and did not physically search clients at any time. They asked clients to tell them about any risky items they had on their person and would search client rooms in response to identified risks. The service imposed many restrictions on clients' freedom and this was part of the therapeutic community approach. For example, clients had to get up at a certain time in the morning and could not spend time in their bedrooms because the regime was highly structured. Clients had household duties to perform and staff engaged them in group therapy and trips out for a large proportion of the day. The purpose of the structure was so clients could learn self-discipline, responsibility and concern for other community members. The clients we spoke with at inspection understood the need for and valued the structure but some of them said they did not know all the rules prior to signing up to the programme. Not all of them had had the opportunity to visit the service but they had been given a tour of the service on arrival where the rules had been explained to them. Clients signed an agreement containing the house rules. Staff told us they planned to have an on-line tour and video so clients who could not visits the service prior to admission could experience the structure and what the routine was like.

Clients could smoke in a designated area outside the main building. Staff told us they could refer clients to the local NHS smoking cessation service and therapy staff supported them to attend off-site appointments as appropriate.

Safeguarding

Staff had completed mandatory training in safeguarding adults and children and, in staff files, we saw evidence of training certificates. Following the inspection, the provider gave us data showing that staff compliance with child and adult safeguarding was 100%. In addition, all staff responsible for key working clients had completed Care Certificate training which included safeguarding modules. The Care Certificate is a recognised set of standards for health and social care workers. The registered manager acted as the safeguarding lead and as such had participated in a higher level of safeguarding training. The registered manager could access advice from support from two senior managers, both of whom had an organisational safeguarding lead role. Staff could give examples of how to protect clients from abuse and were aware of how and when to report safeguarding concerns. For example, we saw how staff had made a child safeguarding referral to the appropriate local authority where a potential new referral made a concerning disclosure during a telephone assessment. The service had up-to-date policies on adult and child safeguarding which contained safe procedures for children to visit clients in the annexe away from the main building. Staff did not allow young people under the age of 16 years of age to visit clients without being accompanied by an appropriate adult. All staff participated in mandatory equality and diversity training which included how to protect clients with protected characteristics under the Equality Act.

Staff access to essential information

Managers had recently introduced electronic record keeping to store most of the information relating to the care of clients at the service. The staff we spoke with found the new system had improved record keeping, particularly in relation to risk assessments and care planning. All staff who had responsibility for providing client care could access care records and this included bank staff and volunteers as appropriate. Staff used a duty book to record some information about clients but then transferred relevant information to the care record each day. Staff also carried out activity risk assessments, for example, concerning trips out with clients and these were recorded separate to the electronic care records system. Staff printed copies for use by workers in the main office so they could see quickly and easily which clients and staff were engaged in an outside activity at any time during the day. Staff kept paper medication records to record medicines administration and withdrawal symptom monitoring. Staff told us that eventually, they intended all records would be available electronically as they found the systems beneficial to evidence good care. They scanned appropriate documents into the care record which meant they could keep client's paper based outcome monitoring securely on the electronic record.

Good

Substance misuse/detoxification

Medicines management

We reviewed the medication administration records for six clients and found staff had completed administration charts correctly. There were appropriate systems and processes in place for the storage and administration of controlled drugs including a controlled drugs book used to record the receipt, administration and disposal of controlled drugs. Keys to the medication room and medication cabinets were stored separately from all other keys and signed in and out from the main office by authorised staff.

Unlike at our previous inspection in July 2017, we found staff recorded the temperature of the medicines fridge consistently and took appropriate action where the temperature was out of the recommended range. Following our previous inspection, the provider had employed a part-time nurse to set up and oversee clinical systems including medicines management processes. Normally, non-nurse trained staff administered medication supported as needed by the nurse. Staff who administered medication had all received appropriate training in medicines administration and were required to demonstrate competence prior to dispensing medication for the first time, which their manager or the nurse reviewed annually. Although the nurse post was currently vacant, a nurse based at the provider's head office supported staff in the interim.

The provider had a service level agreement with a local pharmacy who supplied medication and collected it for disposal as required. The provider had a service level agreement in place with a local GP who provided prescribing input. The referral criteria for the service clearly specified that detoxification regimes were medically monitored rather than medically managed, therefore clients were not prescribed high doses of medication. Staff carried out monthly medication audits covering medicines logging and dispensing. Twice per year the quality team also carried out medication audits which we checked following our inspection. Their most recent audit in July 2018 found no significant concerns.

The provider had revised their medicines management policy in July 2018 and an up-to-date copy was available for staff to reference. The policy was comprehensive and included guidance and procedure relating to medicines storage, prescribing including detoxification, self-administration, withdrawal monitoring and links to other relevant policies, for example, Naloxone. Overall, we found medicines management practices to have improved since our previous inspection.

Track record on safety

In the period August 2017 – July 2018, the provider reported nine serious incidents using their own criteria contained within their incident reporting policy. Seven out of the nine incidents occurred because clients discharged themselves from the service without making staff aware. Staff followed their own protocol by attempting contact and reporting them as missing persons. The other two incidents related to prospective clients undergoing assessment where staff raised safeguarding concerns. Managers told us there had been no injuries to staff in the three months prior to our inspection.

Reporting incidents and learning from when things go wrong

The provider had recently implemented a new electronic incident reporting system which all staff had access to. We saw evidence that staff knew what incidents to report and were encouraged to report different types of incidents including near misses. Whilst on inspection, we reviewed some of the incidents which staff had reported including one medication error which we had identified during our inspection of medicines administration at the premises. The incident occurred on the 3 November 2018 and had been reported by staff on the same day. In the handover meeting which we observed, we saw that managers ensured any incidents from the previous shift were reported by staff and appropriate actions taken.

The provider did not report any incidents meeting the duty of candour threshold but did apologise to a client for a medication error which had impacted on the client but not caused any direct harm. We saw evidence in team meeting minutes that staff discussed lessons learned from incidents on a regular basis. They had made improvements to the safety of the service because of incidents. For example, staff had recently introduced a new information gathering form for when clients were discharged back into the community before completing the programme. The learning took place following an incident whereby staff could not identify crisis accommodation or travel arrangements for a client who was being prematurely discharged by the service. Staff ensured emergency

Good

Substance misuse/detoxification

discharge arrangements were in place for each client prior to entry to the service. Staff told us the service encouraged them to report incidents and discuss feedback from adverse events. They told us they learned how to deal with incidents better through discussion at team meetings and identifying where improvements could be made. All incidents reported locally by the service were seen by senior managers who provided advice as appropriate regarding investigations and recommendations. Staff told us serious incidents were rare but on occasions where there had been aggressive incidents, for example, they received support and debrief from managers following the event.

Local managers could tell us how many incidents had occurred during specific time periods and could demonstrate how they were analysing incidents to identify safety improvements. For example, following a client injury, staff made changes to the activity timetable to avoid all the high intensity sporting activities taking place on consecutive days.

Are substance misuse/detoxification services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Staff completed a comprehensive assessment on all clients prior to admission to the service. The assessment contained information relating to several domains including mental and physical health, forensic history, substance misuse, finances, education and training. Some assessments took place over the telephone but where possible, staff encouraged clients to visit the premises for an assessment in person. Staff told us that where assessments had taken place over the phone, staff would meet with the client on admission to confirm the details contained in the initial assessment. Where clients required detoxification, the prescribing doctor met face-to-face with clients to carry out an appropriate assessment. Where indicated, staff received relevant health related information from the client's GP prior to admission or as soon after as possible.

Physical health monitoring was carried out mainly by a local GP where staff registered clients on admission to the service. However, staff monitored clients' blood pressure, height and weight where necessary and recorded any physical health problems in the client's care record. Staff asked screening questions concerning blood borne viruses but immunisation was carried out in line with the client's wishes through the local GP service. Therapy staff and the nurse supported clients to live healthier lives through appropriate health promotion advice. We saw examples in care records of staff providing healthy eating advice to a client with diabetes.

Staff developed specific plans with clients at risk from unplanned treatment exit. We saw an example where staff planned take-home doses of emergency drugs for a client at risk from early discharge and overdose.

Best practice in treatment and care

As part of our inspection, we reviewed five client care records. Recovery plans were holistic, personalised and contained specific goals relating to the needs of each client. We saw examples of personal evacuation plans for clients with restricted mobility. All the care plans we looked at contained goals linked to the outcome domains in the Recovery Star. This was a tool used by staff to measure client progress in line with relevant domains such as substance misuse, self-care and living skills, mental and physical health, relationships and managing money and time. Records showed that staff regularly reviewed recovery plans and updated them as necessary to achieving client goals.

The programme, which was highly structured was based on the therapeutic community model where staff encouraged clients to use the community as a tool for change. The approach has an evidence base and is abstinence oriented. As part of the structure, staff provided clients with a range of evidence based interventions including activities and opportunities aimed at helping clients acquire living skills. In addition to the therapeutic community method, therapy staff delivered cognitive behavioural based talking therapies with clients on a one-to-one basis and in groups. They delivered relapse prevention strategies and encouraged clients to participate in life story and other written work. Clients told us they found the structure demanding and the written work rewarding and valuable. We saw evidence that staff provided support with benefits and housing advice. The provider had access to move-on

accommodation through their supported living scheme based locally. Medical staff prescribed pharmacological interventions in line with National Institute for Health and Care Excellence, (NICE), guidance. We saw signed copies of detoxification protocols which had been agreed between the provider and the prescribing doctor. This was something we told the provider they should address following our last inspection in July 2017.

Staff participated in audits, for example case file audits and in quality improvement initiatives. The provider aimed to improve their groupwork programme and had a strategy to reduce drug related deaths. They recruited frontline staff to help shape the development of these improvement programmes and used surveys to gather their feedback.

Skilled staff to deliver care

The provider had a mix of staff, some with professional qualifications and some with lived experience of substance misuse. For example, the senior therapy worker was a qualified drug and alcohol practitioner, accredited by the Federation of Drug and Alcohol Professionals, (FDAP). All the staff we spoke with were experienced and knowledgeable about the client group and had access to other training opportunities beyond their mandatory requirements. At the time of our inspection the provider was developing their workforce strategy within the residential projects to ensure staff had a range of opportunities to develop skills in working with the client group. Some staff we spoke with had completed motivational interviewing, groupwork skills training and training in domestic abuse and post-traumatic stress disorder.

Staff told us and we confirmed when we looked at staff records that managers had provided new workers with a structured and thorough induction including where they had moved from other roles within the organisation. All non-managerial staff undertook appropriate training in the Care Certificate, a recognised set of standards for health and social care workers. All the staff files we looked at contained a copy of a Care Certificate training signed by a senior manager in the organisation. In addition, staff undertook training in mental health awareness, managing challenging behaviour, risk assessment and care planning, the principles of the therapeutic community, drug and alcohol awareness training.

Managers provided staff with regular supervision which we confirmed when we looked at a sample of personnel files. When we spoke with staff, they told us managers provided effective regular clinical and managerial supervision. The provider reported 100% of staff had a named supervisor who provided regular supervision. Each staff member had a file containing a record of the dates on which supervision sessions were scheduled to take place and a note to explain if the session had gone ahead as planned and if not, the reason why. We found that overall, staff received regular supervision which was documented and signed by both the supervisor and the supervisee. The minimum supervision requirement was bi-monthly but we saw in practice that staff received supervision more frequently than this. Supervision sessions followed a standard structure and provided staff with opportunities to reflect on personal and professional development issues. When we inspected personnel files and spoke with staff, we could see that staff received regular supervision but the provider could not supply overall compliance figures which meant they might not be able to assure themselves that staff always received supervision in line with organisational requirements.

Managers provided staff with an annual appraisal of their work performance. Data provided by the organisation showed that 100% of staff who required an appraisal had received one within the previous 12 months. We saw evidence of probationary reviews taking place with new staff who had not been with the provider long enough to qualify for an annual appraisal. Appraisals followed a standard structure with a review of the previous 12 months and a development plan with review dates. Workers had the opportunity to input into the appraisal which also included a review of additional training needs. Staff had access to regular team meetings which also followed a standard structure.

Managers were supported by a corporate human resources function to deal with poor staff performance. We saw evidence of improvement plans in staff files and we could see that managers had access to appropriate management development training to enable them to support staff. This included supervision skills training which all supervisors had undertaken.

Good

Substance misuse/detoxification

At the time of our inspection, the service had two active volunteer staff. Both were supported to facilitate client information groups by the senior therapy worker who also provided them with regular supervision.

Multi-disciplinary and inter-agency team work

Staff did not engage in multi-disciplinary team meetings but held a main handover meeting each morning with managers and all the therapy staff on duty for that day. As part of our inspection, we observed a handover meeting. We saw that staff communicated effectively with each other about the events of the day including what activities would be taking place off-site and what appointments clients had. The handover also included a space for one of the more senior peers to feedback any concerns about current clients. Therapy workers provided feedback about any clients who had found the group work therapy particularly difficult so staff could ensure they supported them effectively throughout the day. Staff recorded notes from the meeting in the duty book so they could relay the information to staff when they came in for the evening and night shift. Managers ensured that staff transferred relevant information to client care files, for example, risk management plans.

Staff had developed good links with community mental health services locally and one client was being supported by their community psychiatric nurse who visited the service regularly. We saw examples where staff facilitated support for a client with post-traumatic stress disorder. Clients had good access to GP services and all residents had been registered with the local primary care service. Staff told us and we saw from clients' recovery plans that staff had liaised effectively with the local crisis team for a client with self-harming behaviour. They had also liaised with a specialist eating disorder service for a client who needed specialist support. Staff felt that working with other community organisations had greatly improved since the last inspection in 2017.

Good practice in applying the Mental Capacity Act

All staff had completed the Care Certificate which included a module covering mental capacity. In addition, 100% of staff had completed further on-line training in the Mental Capacity Act which, included training in the Deprivation of Liberty Safeguards. The provider had an up-to-date policy on the application of the Mental Capacity Act and Deprivation of Liberty Safeguards which staff were aware of. Electronic copies were available on the provider's intranet which all staff had access to.

The staff we spoke with demonstrated an awareness of the principles of the Act and the need to assess clients' capacity on an on-going basis. Staff told us where they had concerns, they would seek advice from local or higher managers. Staff could seek advice from the nurse employed at the service or the clinical quality manager who worked at head office. Staff showed an understanding of the concepts of unwise decision making and best interest decisions and they could give us examples. They presumed clients had capacity to consent to treatment and make relevant decisions for themselves. We did not see any examples where staff had carried our formal assessments of capacity, although staff told us there was a capacity assessment form to enable them to do this if needed. When we looked at care records, we did not see any instances where staff should have questioned a client's capacity but there was one record where staff had considered whether the client's memory loss had impacted on their capacity and had sought advice from a clinician.

Staff demonstrated an understanding of the Deprivation of Liberty safeguards and told us if a client wanted to leave they would not be able to stop them from doing so, though they would always try to assist clients to discharge themselves in a more planned way if that was their final decision.

Staff ensured clients consented to treatment and this was recorded clearly on the assessment form and in subsequent admissions paperwork. Staff also sought specific consent to enable the service to share personal data with the National Drug Treatment Monitoring System or NDTMS. This was in line with god practice guidance issued by Public Health England.

Are substance misuse/detoxification services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Good

Substance misuse/detoxification

As part of our inspection, we spoke with seven clients and three carers. We also observed a therapy group. Clients told us staff were respectful of their privacy, supportive and encouraging. Staff provided them with practical and emotional support though some clients did not feel there were enough staff around in the evenings or at weekends if they had high support needs. Overall, clients thought staff did an amazing job and were genuinely caring despite the therapy being quite challenging at times. All the carers we spoke with reported positive interactions with staff. They told us staff treated them and their loved ones with kindness and compassion. Two carers told us their relative had been supported by staff to access specialist services for their mental health condition. They told us staff were always available when they visited and they could ring the service to speak with staff if they had any concerns. The clients and the carers we spoke with told us staff understood their individual needs and supported them to access specialist and other services as needed. When we observed the therapy group, we saw how staff motivated clients and encouraged them when they contributed to the meeting. Clients told us the therapy was a useful source of support and helped them understand their addiction and emotional needs.

The service carried out local client satisfaction surveys regularly. The last survey they carried out was in 2018 and the results were based on responses from fourteen residents. The results showed that two out of fourteen clients thought the service overall was excellent, three thought it was very good and seven thought it was good. Two clients thought the service was average. When asked whether the clients would recommend the service to their families and friends, 93% said they would. All the staff we spoke with were very clear that they could raise concerns about disrespectful or discriminatory behaviour without fear of the consequences. Overall, clients reported that staff treated them well and always behaved appropriately towards them.

Staff maintained client confidentiality and information sharing agreements were clearly visible in care records. Staff explained confidentiality thoroughly to clients and updated information sharing agreements as needed. All care records we checked showed clients has signed consent and information sharing agreements. Clients told us staff consulted with them regularly about information sharing and checked with them verbally where required before sharing personal information with others.

Involvement in care

All the care records we looked at contained a recovery care plan with specific goals appropriate and tailored to the needs of each client. A small number of clients had copies of their care plans but records indicated that clients were routinely offered a copy. Care plans were holistic and focussed not just on the substance use but also on other aspects of the clients lives such as social networks and relationships, self-care and living skills, meaningful use of time and emotional health. Care plans were signed by clients and staff scanned them back into their care record. We saw evidence that clients were involved in updating risk assessments, for example, when planning to go on home-leave. Staff involved clients in completing an outcome star at regular intervals. The outcome star allowed clients to assess their progress in relation to their substance use and other related domains such as their living skills and social networks. Therapy workers assisted clients to complete the star and to look at their own progress over time.

Staff involved clients in decisions about the service, for example via a regular service user forum chaired by a national service user representative or someone who had graduated from the programme previously. We looked at the previous meeting minutes for May and July 2018. Representatives encouraged clients to make suggestions for improvement, for example, clients wanted more physical activity on the programme so staff arranged a bike ride and changed the day of the circuits and yoga classes so more clients could attend. Staff had a written record of what was discussed and responded to issues raised by clients using a 'you said, we did' board which they displayed in the service. Staff involved clients in recruiting new staff as appropriate depending on their stage of recovery. Clients sat on interview panels and had the chance to ask questions of potential candidates.

Staff could direct clients to the local advocacy service in Sheffield but the clients we asked about this felt they didn't really need it. Clients told us the service had service user representatives in place who could advocate on their behalf as needed.

Involvement of families and carers.

As part of our inspection, we spoke with three carers about their experiences of the service. We also spoke with clients about how the service involved their families and carers. All

Good

Substance misuse/detoxification

the clients and carers we spoke with told us staff supported them to maintain contact with their families according to their wishes and needs. Carers felt involved and could visit the service to see their relative. Clients and relatives wrote to each other and spoke on the telephone. Carers described how staff supported them with advice and information where appropriate within the bounds of confidentiality. Staff told us about a new carers group they planned to start at weekends which was when most family visits took place. Managers told us that since they had made changes to the staff rota, it was a lot easier for staff to meet family members and respond to their needs. Managers encouraged therapy workers to contact clients' families within the first week of treatment.

We did not see that the provider had any formal mechanisms in place for carers to give feedback about the service and the carers we spoke with had not been provided with information about how to access a carer's assessment. Managers of the service acknowledged that there was more the service could do to involve families and they were looking to develop this provision.

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

Good

Access and discharge

At the time of our inspection, the service had 27 clients in total. Managers told us the therapeutic community needed about 24 residents to function well and ensure all the roles in the house such as cooking and cleaning could be carried out by residents. Operational managers had access to occupancy rates on quarterly basis and the service had an average bed occupancy of 28 clients for quarters one and two in the year 2018 - 2019. This was above their average occupancy target of 26. In the same period, they discharged 55 clients with 51% having completed treatment. A small proportion, 7% were transferred to other Phoenix Futures residential projects as these were better able to meet those clients' needs and 8% of clients dropped out of treatment. The remaining 27% of clients did not complete the programme but staff supported them to transfer to further community treatment. As part of our inspection, we gathered feedback from four service commissioners. They all spoke positively about the provider but two specifically mentioned the strengths of the service were about retaining clients in the programme and supporting clients in their transition to other residential or community services.

In the main, clients were referred though their local authority care manager but some clients were self-funded. The service had clear criteria for referrals and one of the staff was primarily responsible for ensuring staff obtained thorough information about clients' needs at the referral stage. This included a medical summary from the client's GP indicating any mental or physical health complications. Managers told us that potential clients with an offending background would be considered carefully if the offending related to anything which could pose a significant risk to other clients or staff. Staff ensured they spoke with other professionals who were involved with the client so they could gain as much background information as possible to ensure suitability for the programme. Staff told us that the safety of clients and staff was their overriding concern and they gave us examples of where they had refused admission to referrals because the service was not equipped to meet their needs. The referral criteria for pharmacological interventions specified that detoxification regimes were medically monitored rather than medically managed.

The service did not admit emergency referrals but they responded to requests for assessments promptly. As part of our inspection, we received feedback from four service commissioners. They all spoke very positively about the responsiveness of the service and thought that overall, staff were good at communicating with them about client referral, admission and discharge. However, one commissioner thought the waiting time from the assessment to staff deciding about eligibility could be improved. Managers told us they sometimes had to consult their insurers when making decisions about referrals and this could take time.

Staff were discharge oriented and discussed with clients plans for discharge at the start of the programme. The provider had move-on accommodation which many clients went on to as part of their aftercare. Staff ensured that clients had emergency arrangements in place if they left the service in an unplanned way and they discussed these with the referrers prior to entry into treatment. All the

commissioners we received feedback from thought the service was very effective at communicating with care managers and care coordinators and keeping them informed. They also thought the service supported clients well during transfers to other services where they had additional care and support needs. All clients had a discharge pack prior to leaving the service whether or not they left in a planned way. The pack contained personalised information about coping skills, sources of support and relapse prevention strategies.

The facilities promote recovery, comfort, dignity and confidentiality

Clients did not have their own bedrooms and slept in shared rooms with several other clients. This was made clear to clients both at the referral stage and in the welcome information. Two of the bedrooms were en-suite but clients had several communal bathrooms they could use on each floor which were situated close to the bedrooms. Staff told us that sharing rooms and facilities was part of the therapeutic approach to foster community living and mutual trust and responsibility. The service had a range of rooms including a communal lounge with a television, a group room with a pool table and football table, a separate clinic room, a spacious dining room, kitchen and a computer room. Clients could see visitors in the lounge of the annexe where female clients slept. Clients had access to a large garden area and an outside smoking shelter.

Clients could personalise their rooms and had access to drinks and snacks in the kitchen area. We saw fruit and other food available but clients were encouraged to eat main meals with the other clients in the community at set times. All the meals were prepared by clients overseen by a member of staff. Some of the clients we spoke with told us the food was poor with an over-reliance on carbohydrates but in the service user forum in May and July 2018, clients chose to comment on the food as being healthy and a strength of the service. Clients were looking forward to growing their own food through the new social enterprise initiative. Following the inspection, we looked at the four weeks' food menus from 22 October 2018 to 5 November 2018. We found that each day the kitchen offered a salad bar in addition to the main evening meal. Fresh fruit was on offer at breakfast in addition to cereals, toast and porridge and clients could choose vegetarian options which were available each meal time. However, we found the food choices to be repetitive. For example, of the four weeks' menus we looked at, we saw shepherds' pie every Saturday, sausages and mash every Wednesday and burgers and chips every Monday and every Thursday except Thursday 5 November, when there was cheese quiche. Each Sunday, there was a roast dinner with lamb pork or beef on a rotating basis.

Overall, staff encouraged clients to maintain contact with their families and carers and we confirmed this when we spoke with clients and carers. The service had two payphones which clients could use in the evening to keep in touch with people who mattered to them. In July 2018 clients reported that one of the phones was consistently not working but in the follow-up meeting, in September 2018, staff reported that two new payphones and a maintenance contract had been installed and that if clients had any further problems, an engineer would attend and repair or replace the phone. Clients could also make phone calls to their children up to three times per week using the provider's telephone in a private office.

Patients' engagement with the wider community

Some clients told us the service did not encourage them to access the local community and activities, however, staff told us they had made significant changes to the timetable to encourage more community engagement. In the service user forum in July 2018, clients talked positively about the new programme and in particular the park run and Purple Camel project. Every Saturday, staff encouraged clients to engage with the local park run in Sheffield as a way of connecting with the local community. Clients could walk rather than run or could volunteer to help organise the event. The Purple Camel project was a new social enterprise initiative developed by staff but led by clients who formed the steering group to the project. The project's aim was to help the clients grow their own food and eventually to sell surplus produce locally. Clients were developing new skills and learning about food production. This was part of the provider's strategy of enabling clients the chance to become involved in real work opportunities and help them develop their employability. Clients could undertake qualifications in food preparation and health and safety. The service also had many volunteers and paid staff who had been through the programme themselves and gone on to become qualified to help others.

Meeting the needs of all people who use the service

Good

Substance misuse/detoxification

The building which was leased by the provider was a listed building in a conservation area so staff were limited in the adjustments they could make for people who required disabled access. For example, there were several steep steps to enter the building and once inside, there were more stairs up to client rooms. Staff told us if needed, they could accommodate clients with mobility needs in the annexe which had a bedroom and a bathroom on the ground floor but access to the other areas of the house would be limited depending on the needs of the individual.

Each morning, clients met as a peer group to discuss feelings and needs for the day. They would then relay these to staff through a senior peer at the main daily handover meeting. In general, clients thought staff were responsive to meeting their needs but in the service user forum minutes of July 2018, we saw that clients had raised the issue saying that client needs from the morning meeting were not being met. In September 2018, clients in the service user forum acknowledged that staff were improving in this area but we spoke to one client on inspection who told us they had raised a need on their feedback sheet but it had not been met. Staff explained that clients with more pressing needs had taken priority but they had not given a timescale by which the client's need would be met. However, we also saw examples where staff were responsive to client need. At our inspection visit, staff transported and attended a family funeral with a client. Through the service user forum, clients had raised they needed a wider range of physical activities so residents with different abilities could take part. In response to this, staff had organised yoga and massage sessions in addition to gym sessions and circuit training.

Staff ensured clients had access to appropriate spiritual support by supporting them to attend local facilities. Staff had developed good links with local Christian and Islamic Centres' to ensure clients could attend services and religious celebrations. Clients could access interpreters when needed and the staff could produce information in the client's preferred language as required. Clients told us peers on kitchen duty would ensure any specific food requirements such as allergies or intolerances would be catered for and clients could request food to meet their cultural or religious needs. A member of staff who acted as the kitchen coordinator ensured clients carried out kitchen duties with attention to the specific dietary needs of clients. When we checked a sample of menus, we could see that each day, there was a vegetarian and a halal food option. Staff demonstrated an understanding of the issues facing vulnerable groups and had, for example, worked to support LGBT clients resident in the service. The provider had a strategy in place aimed at reducing stigma and promoting the service user voice.

Listening to and learning from concerns and complaints

The provider had a thorough complaints procedure in place and during the period, August 2017 to July 2018, they had received five complaints, three of which were upheld. In the same period, the service received 10 compliments. Staff had a proactive approach to dealing with complaints and clients could either speak with or write to a member of staff or they could raise the complaint at a regular service user forum. We saw posters displayed in the service about how clients could make a complaint. We also saw information about how clients could contact CQC with any concerns about care. Whilst we were on inspection, we saw an example where a client wanted to make a complaint about a medication error. We saw how the manager arranged to meet the client straight away to apologise and offer an explanation. Managers also told us about a situation where they had received a complaint about a worker's attitude and had, as a result, taken appropriate disciplinary action.

Staff discussed complaints as part of their team meetings and responded to concerns raised at the regular service user forum. Staff could meet one-to-one with clients each morning or evening if they had any individual concerns they wanted staff to take action about. The provider had timescales for responding to formal complaints and we could see from the data they submitted that they dealt with complaints within the timescales set out in their policy.

Are substance misuse/detoxification services well-led?

Good

Leadership

Managers of the service were knowledgeable and experienced both in addiction recovery approaches and in management. Some leaders had graduated from the programme themselves and some had worked for the provider for many years, starting out in other roles. Both

the registered manager and the programme manager had undertaken management skills training and those managers required to carry out supervision with staff had undergone supervision skills training. The registered manager had recently undergone further leadership training. Some staff took lead roles, within the service and examples included a service user lead, a medication lead, a mental health lead and an eating disorder lead. All staff, regardless of their role had the opportunity to participate in leadership development training.

All the staff we spoke with confirmed managers were visible in the service and senior managers visited services regularly. The director of operations let staff know when they planned to visit services and encouraged staff to speak with them about any issues concerning the service. Staff and clients knew the local managers well and interacted with them daily. Staff told us they were approachable, helpful and would listen to any concerns they had. Staff told us the chief executive officer would know individual staff by name.

The provider had put in place a new learning and development policy to encourage life-long learning and increase opportunities for staff to participate in development opportunities beyond their mandatory and role specific training. All the staff we spoke with told us they valued the training opportunities on offer and confirmed they were encouraged by managers to develop to their potential.

Vision and strategy

The provider had strong values which staff could describe. These were focussed on valuing history and being passionate about recovery. Staff also believed in being the best by delivering quality and continuous improvement. The staff and managers we met were passionate about recovery and within the service, there were numerous references to the organisation's history as a therapeutic community. The managers we spoke with were focussed on continuous improvement and could tell us how their vision and values impacted on the work of the teams.

The staff we spoke with told us the senior leadership team held a road show every year where they would meet with front line staff to share the strategy and gain their views. In 2018, senior managers had launched a new strategy specific to the residential services. Staff knew about the strategy and local managers could describe the different stages and the expected business impact. The provider had implemented a new staffing structure with new roles and a new staffing rota. Staff understood why the changes were necessary and could describe how the new approach impacted positively on client care. For example, staff described how the changes to the rota allowed additional staff to be present during busy times, for example at morning medication. The new strategy aimed to develop client skills to improve their employability and the provider was piloting the new programme in one of their other residential services before implementing it fully within the Sheffield residential service.

Culture

Staff felt proud to work for the provider and told us they felt valued and respected. In 2018, Phoenix Futures was recognised by Best Companies as being a "Very Good" employer and for the third consecutive year achieved a placing in the Sunday Times Top 100 not-for-profit organisations to work for. The provider commissioned independent annual surveys with residential staff but these could not be disaggregated to the local service level. However, the staff we spoke with at inspection and at the focus group said they felt supported by their immediate managers and thought the team worked well together. They valued events which involved other residential services, for example, the family service as this gave them opportunities to get to know other staff and learn new things.

Staff told us the provider held an annual staff awards ceremony where they could nominate colleagues for awards. The chief executive officer sent a newsletter round every quarter to all staff where individual and team achievements were mentioned. Staff thought the organisation was good at celebrating success because in supervision and in team meetings, there were standard agenda items about what had gone well and what individuals and teams had achieved in a particular time frame. Staff had access to employee assistance programmes and could access independent support for their own health and well-being via a telephone helpline. They

also had access to practical support and counselling where necessary through the scheme. Managers spoke with staff in supervision and appraisal about their overall well-being

and career development. Staff sickness and turnover were low in the service. From the period August 2017 to July 2018, the provider reported that only one member of staff had left the service and sickness was 1.3%.

In the period August 2017 to July 2018, the provider reported no cases of bullying or harassment at the service and when we spoke with staff, they confirmed this. Staff knew how to raise concerns and felt able to do this without fear of retribution. All the staff we spoke with felt the provider had an open culture where staff could raise concerns with managers including higher managers. They talked with us about the organisation's whistleblowing procedures and that they had a named senior manager they could approach with concerns as needed. Managers were supported by a corporate human resources department to deal with staff underperformance. We saw examples of managers carrying out probationary reviews and improvement plans with staff.

Governance

Since our last inspection in July 2017, the provider had commissioned an independent review of the residential provision and, as a result had made improvements to the governance structures and audit systems in place. For example, the service had employed a nurse to support clinical practice within the service and this together with other measures had resulted in improved medicines management practices. The provider had developed a clear set of mandatory training requirements and ensured they could measure and report on staff compliance with training. They had implemented an electronic incident reporting system which allowed higher managers more oversight regarding incidents. Staff were clear about incident reporting unlike at our previous inspection in July 2017 when they were not always clear which incidents to report. The provider had implemented an electronic case recording system which had improved the quality of risk assessments, risk management planning and care planning generally. The provider could show that staff had good access to supervision and appraisal and that they consulted with staff and clients regularly to improve the service. The provider had an equality and diversity strategy with appropriate policies and procedures in place, however, they did not carry out equality impact assessments to ensure they did not disadvantage people with protected characteristics.

Staff carried out a range of audits and were also involved in peer auditing each other's care records. The head of quality and performance carried out unannounced audits in the service on a regular basis and the subsequent improvement plans were more specific and contained timescales for action unlike at our last inspection where we found improvement plans were vague regarding actions and timescales. Following our inspection, we asked the provider for their latest action plan concerning the adult residential service. We could see that the quality team had identified areas for improvement based on their last audit. The improvement plan was reviewed regularly by the registered manager who carried out the appropriate actions and indicated whether they were complete. The operations director then reviewed the plans to ensure the actions had been carried out. However, on the most recent improvement plan, we could see that reviews had taken place on 4 September 2018, but the plan did not indicate the correct next review date. Neither could we see anywhere on the plan to indicate if the completed actions had been checked by the operations manager. The director of operations told us they reviewed action plans in supervision with the relevant service manager every six weeks. The registered manager of the service confirmed this when we spoke with them at inspection. The head of quality and performance told us they would re-visit service improvement plans when they carried out subsequent audits and would highlight any ongoing concerns to the relevant managers.

Team meetings and service manager meetings contained standard agenda items to ensure staff regularly discussed essential information such as learning from incidents and service user feedback. The provider had a written framework showing which meetings particular discussions should take place in and the frequency.

Staff had been involved in developing the organisation's strategy to reduce drug related deaths and as a result had introduced the use of emergency medication into relapse prevention planning for some service users they assessed to be at high risk from drug overdose. On a quarterly basis, the director of operations met with the residential service managers to discuss operational issues and key performance indicators. The operations director then reported issues through to the Board via quarterly clinical governance meetings.

Management of risk, issues and performance

Good

Substance misuse/detoxification

The service had a recognised quality assurance framework in place called the European Foundation for Quality Management or EFQM. Every two years, the service was externally assessed against specific management standards by the British Quality Foundation. The head of quality and performance told us the provider had a five-star rating which meant they were recognised as a higher performing organisation with a sustainable business model.

The service had a risk register in place but the managers we spoke with locally were not sure what this contained. We did see that they met with higher managers regularly and they could discuss and, where necessary escalate concerns. Some of the concerns on the corporate risk register matched the concerns of local managers, for example, cuts to substance misuse budgets and the increasing complexity of clients' mental and physical health needs. The service had a local business continuity plan to cover, for example, what action staff should take in the event of serious disruption to services. We could see that staff had plans in place, for example, to cover emergency accommodation for clients in case of serious problems with the facilities. We also saw that staff kept paper copies of client emergency contact details and most recent risk assessments in case of lack of access to the electronic care records.

Information management

The service worked to a number of key performance indicators and each quarter, mangers received information regarding bed occupancy, client planed exits form the service, staff sickness levels and staff vacancies and financial performance. Local managers reviewed these with the director of operations quarterly in supervision. Managers reviewed some items such as financial performance and occupancy levels more frequently by email and by telephone. Managers showed us their latest key performance indicator report for the first two quarters from the start of April to the end of September 2018. The report showed the service exceeded or had met its own target for occupancy, treatment completions and transfers of treatment. The report showed their performance to be below the providers target for unplanned exits from treatment, outcome star compliance and Treatment Outcome Profile, (TOP) compliance. Managers said they discussed these indicators and where performance needed to improve at regular supervision sessions. For example, in relation to unplanned exits from treatment, managers told us they scrutinised and discussed each unplanned exit to identify ways of preventing early discharge. Managers had access to outcome star results which was based on clients' self-reports about their own health and well-being across a range of relevant domains. The reports showed clients improved from the start of treatment in areas like physical health, substance misuse, meaning full use of time, relationships and self-care. In the performance reports, we did not see the provider had set any targets for sickness absence or for financial performance. Managers told us they were developing their approach to monitor the performance of local services.

Since we last inspected the service in July 2017, the provider had made significant improvements to systems and information management. For example, electronic care records and incident report systems were in place. Managers could access key performance data such as outcome star results and client discharge data. The quality team were conducting remote audits of care plans through the new electronic system. Although we could see improvements, we thought the key performance monitoring at the service level was still an area under development. In the reports the provider sent us and in the ones, we looked at on-site, we did not see performance indicators for financial planning, staff compliance with mandatory training, or vacant posts. We did not see targets for sickness monitoring or other staffing performance indicators. This might mean that local managers were not clear about how their service was performing in relation to other Phoenix projects or other providers nationally.

Engagement

Staff had up-to-date information about the work of the provider through regular newsletters which corporate staff sent out every two weeks. Staff also had access to an intranet. Clients had the opportunity to give feedback through exit interviews, suggestions boxes and through service user feedback meetings. The service was developing feedback mechanisms for carers but all the carers we spoke with as part of the inspection described very positive experiences of the service and the staff. The service had a new service user involvement strategy and, at a national level the provider was planning a range of projects to help bring together the voices of people

affected by addiction and those working towards a more recovery friendly society. We saw leaflets in the service advertising how clients could get involved and links to a social media campaign.

Learning, continuous improvement and innovation

Service managers told us and we confirmed through meeting minutes that they met with other residential managers in the Phoenix group to share good practice. We saw examples where local managers had used tools to help clients with self-harming behaviour that they had learned about through contact with their peers.

The provider measured the business sustainability through their participation in the European Foundation for Quality Management. Staff had individual objectives in their annual appraisals which managers reviewed in supervision. The provider had an annual awards scheme and a newsletter where individual staff would be mentioned if they had any notable achievements.

The residential service had developed a social enterprise by transforming the garden into an allotment. The project was part of the provider's new residential strategy to collaborate on a sustainable food cycle programme. The purpose of the project was for the service to supply organic food to the kitchen with the future aim of selling any surplus to the local community. Clients and staff at the service were excited by the new initiative which would eventually give clients the chance to be involved in a real work environment and gain new skills.

In January 2017, the provider published an evidence review jointly with Sheffield and Hallam University concerning the effectiveness of residential treatment and, the evidence regarding the therapeutic community model.

Outstanding practice and areas for improvement

Outstanding practice

The staff in the residential service had developed a social enterprise by transforming the garden into an allotment. The project was part of the provider's new residential strategy to collaborate on a sustainable food cycle programme. Staff had collaborated with other local community groups who were also involved in delivering the project. The purpose of the project was to enable clients to grow all their own fruit and vegetables for use in the kitchen, with the future aim of selling any surplus to the local community. Clients would have the chance to be involved in a real work environment and gain new skills. Some clients had already been involved in transforming the garden area and planting was well underway. Staff provided support and guidance to clients by organising the necessary tools and machinery but clients were leading on the project steering group.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that the defibrillator is placed in an openly accessible area to allow immediate access in an emergency.
- The provider should ensure client's crisis plans contain the number of the appropriate local crisis service.
- The provider should ensure that where staff cannot respond immediately to clients' needs from the morning meetings, they are given a timescale for when the need should be met.
- The provider should consider how they can increase the variety of meal choices available to clients.
- The provider should ensure that service improvement plans indicate when completed actions have been checked in line with their own policies.
- The provider should ensure they have oversight of compliance rates for supervision so they can assure themselves staff are receiving supervision in line with organisational requirements.
- The provider should consider implementing equality impact assessments when they review existing or develop new policies for the organisation.