Bank Parade

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:

- The service had enough staff to care for the number of clients and their level of need. Staff knew and put into practice the service's values, and they knew and had contact with managers at all levels.
- Client risk assessments were completed, monitored and managed at regular intervals prior to and during treatment.
- Staff were up to date with all mandatory training. Managers encouraged staff to attend specialist internal and external training to increase staff's knowledge and understanding of substance misuse.
- Clients in vulnerable circumstances were identified and supported appropriately. This included clients who were victims of domestic abuse. The service had links to domestic abuse support services and supported clients to engage in the support available.

Summary of findings

- Housing needs were considered throughout the treatment process. The service employed a housing support worker. Clients were supported to access appropriate housing to meet their short and long term needs.
- Clients felt they were fully involved in their care. Copies of recovery plans had been offered to clients and client records demonstrated collaborative working.
- The service planned and delivered treatment in a way that met the changing needs of clients, commissioners and the local population. A new day service had been developed. This meant that clients unable to attend residential settings could access substance misuse rehabilitation within their local area.

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

- There were blanket restrictions in place that were not reviewed individually or at regular intervals. This was not in keeping with the recovery model and did not prepare clients for their discharge to the community.
- Recovery plans were not completed in a timely manner. This meant that client's recovery plans were not clear at the beginning of the treatment pathway.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services		Not yet rated

Summary of findings

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Bank Parade

Services we looked at
Substance misuse services

Summary of this inspection

Background to Bank Parade

Bank Parade is a six bed substance misuse residential rehabilitation centre for clients who have undergone alcohol or drug detoxification at other services. The service provides 12 weeks of substance misuse treatment for both male and female clients in the centre of Burnley. In addition to this, non-residential clients can also attend the programme during the day. The treatment consists of a range of psychosocial interventions to prevent future substance misuse.

Bank Parade clients are funded by a number of local authorities from the surrounding areas and at the time of inspection there was one client self-funding their treatment.

Bank Parade is registered for accommodation for persons who require treatment for substance misuse. At the time of inspection the service was in the process of registering a new manager and checks were underway. A registered manager had previously been in post and had spent time working alongside the new manager.

The service has been open since August 2016 and has not previously been inspected.

Our inspection team

The team that inspected the service comprised CQC inspector Clare Fell (inspection lead), and one other CQC 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.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location and asked other organisations for information.

During the inspection visit, the inspection team:

- visited the location, looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with seven clients
- spoke with the service manager and the project director

Summary of this inspection

- spoke with four other staff members employed by the service
- received feedback about the service from seven care co-ordinators or commissioners
- spoke with one peer support volunteer
- spoke with three carers
- looked at three care and treatment records, including medicines records, for clients
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

Clients were positive about the care and treatment they had received. Clients spoke particularly highly of the support they had from staff. Clients felt that staff went above and beyond their job roles in ensuring that clients were supported both emotionally and practically. Clients identified that the high number of staff and volunteers being in recovery has helped shape an enthusiastic and committed culture within the service.

Carers also gave very positive feedback. Carers highlighted how well they were supported by telephone updates, meetings, family group work and family one to one sessions. Carers felt that staff were excellent and were always available to offer support.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The service had enough staff to care for the number of clients and their level of need. Vacancy rates, turnover and sickness absence were all low. There had been no use of bank or agency staff. This meant that clients were supported by a consistent staff team providing continuity to clients.
- All mandatory training had been completed by all staff and volunteers. This meant that staff were up to date with best practice in treatment and care and local operational procedures.
- Risk assessments had been completed to a good standard prior to admission and at regular intervals thereafter. Risk assessments informed risk management plans which included unexpected exit from treatment. This meant that staff were well informed regarding individual client risks and that risks were planned and managed.

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

- Blanket restrictions were in place and there were reasonable explanations given for the blanket restrictions. However, they were not reviewed to reflect the progress of the client in their treatment pathway.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Comprehensive assessments were completed prior to clients being accepted into the service. Assessments included information about substance misuse and physical health needs. This meant that client's needs were considered holistically.
- Care was delivered as recommended by national guidelines. Therapy sessions involved group work, individual therapy, family work and aftercare. This meant that clients had opportunities to address many aspects of their recovery in different formats.

Summary of this inspection

- A high percentage of staff and volunteers had lived experience of substance misuse and were in recovery. This reflects national guidelines relating to the importance of good peer support. This meant that there was a greater empathy, mutual respect and understanding between clients, staff and volunteers.
- Access to specialist training was abundant and staff were actively encouraged to attend. Staff had completed external training which was funded by the organisation in some cases. This meant that staff had specialist knowledge and skills to fulfil their role.
- There was a robust system for referral, admission and discharge of clients. This meant that the transition in and out of the service was assessed and planned to increase the likelihood of successful treatment outcomes.

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

- Recovery plans were not completed in a timely manner. This meant that client's recovery plans were not clear at the beginning of the treatment pathway.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff displayed respectful and non-judgemental attitudes towards clients. There was a natural balance between staff effectively challenging clients past negative behaviour whilst maintaining a caring and professional approach.
- Clients were involved in their care as much as possible. Clients were offered copies of their recovery plans and client records demonstrated collaborative working. This meant that clients were active partners in their recovery and more likely to succeed.
- Families and carers were well supported. There was access to a structured programme of family support as well as informal support opportunities. There was support available for families and carers throughout the recovery pathway.
- Clients were encouraged to become actively involved in the service by volunteering within the service following discharge. A high proportion of staff and volunteers had previously been substance misuse clients.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

Summary of this inspection

- Clients had control of meal planning, budgeting, and grocery shopping. Clients were responsible for cooking communal meals for all residential clients. This meant that clients had a choice of meals and had input in deciding weekly menu plans.
- There was a structured programme of therapeutic activities to promote recovery available Monday to Friday. Group social activities were planned for each Saturday. Family visits were arranged every Sunday. This meant that clients were occupied and social isolation was minimised.
- Vulnerable clients were identified and supported by the service. There were links with other local services who offered specialised care. The service employed a housing support worker who could help rehouse clients who were homeless.
- There was a choice of treatment options available to clients prior to admission. Clients were well informed about treatment options and supported to make independent decisions.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff morale and job satisfaction were high. Staff reported feeling valued by the senior management team who were described as approachable and visible. Staff felt they could approach managers with any issues or concerns.
- The senior management team were proactive and innovative in relation to funding gaps within substance misuse services. Managers were able to diversify service provision to provide a community day service, which better met the needs of some commissioners and clients.
- There were effective systems in place to ensure staff were trained, supervised and appraised in line with policies and procedures.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

All clients' mental capacity to consent to treatment had been assessed as part of the assessment and admission process. Staff had received training on the Mental Capacity Act and deprivation of liberty safeguards as part of the induction and mandatory safeguarding training.

The service did not accept referrals for people with severe and enduring mental illness, learning disability or memory problems. This meant the likelihood of needing to use the Mental Capacity Act was minimal.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

Male and female bedrooms were on separate floors of the building in order to comply with guidance on same sex accommodation. There was a female only bathroom on the female only floor.

The service did not store any emergency medication or resuscitation equipment at the time of the inspection. There were plans in place to install a defibrillator and train staff on how to use it. The defibrillator was due to be installed in June 2017 and training undertaken in the following months.

All areas were clean, tidy and well-maintained. The service employed a live in caretaker to complete any minor repairs. Larger repairs were reported to the maintenance department. Clients were responsible for the day to day cleaning of the bedrooms and communal areas. This was a rota system to ensure jobs were shared fairly. A cleaner was employed twice a week to deep clean the building. The caretaker checked the bedrooms regularly to ensure they were safe and clean. Building checks were a standing item on the daily meeting agenda. All bedrooms were spacious with new furniture and fittings. Clients could report repairs to staff during weekly client house meetings.

A registered manager from another Acorn service completed a premises audit in January 2017. The service had commissioned an independent health and safety audit in February 2017. Both incorporated fire safety. There were actions identified which had been completed or were due to be completed. A specific fire risk assessment for the building was scheduled for 26 May 2017.

There were identified fire wardens on each working shift that were noted in the flash meetings held Monday to Friday. Fire warden training had been provided by the health and safety manager.

Safe staffing

The service employed the following number of staff:

- five permanent staff members (a lead counsellor, a trainee counsellor, a manager, a housing worker, a caretaker)
- two substance misuse volunteers

There were no vacancies in the three months prior to inspection and sickness levels were below one percent. There had been no bank or agency usage in the last six months.

Staffing levels had been estimated by the number of clients and client's needs. If necessary, permanent staff were asked to work extra hours to accommodate specific client needs, annual leave or sickness.

The staffing rotas ensured that there was a staff member on site to support clients at all times. Clients told us there was enough staff so that clients could have individual support if needed.

Group or individual activities were never cancelled due to lack of staffing.

Medical cover was provided by a local GP practice during day time hours. During evenings or weekends, medical advice was sought from hospitals and national helplines. There was an on-call duty system for staff to contact managers in the event of any incidents or emergencies.

Mandatory training modules had been completed by 100% of staff and volunteers in the following training courses:

- introduction to Calico/Acorn

- safeguarding
- information governance and data protection
- health and safety
- equality and diversity
- complaint handling
- boundaries
- conflict resolution
- communication and listening skills
- emergency first aid
- medication management
- food safety level 2
- safeguarding – external multi agency
- drug and alcohol testing training
- case note training
- care plan and risk assessment training

Staff described the training as good quality and easily available.

Assessing and managing risk to clients and staff

Staff did not use physical restraint. Clients who presented with a high risk of violence were not accepted into the service and signposted on to other services. In the event of a violent incident, staff were trained to use de-escalation techniques and discuss angry outbursts within group and individual counselling sessions. If necessary, staff would contact the police for assistance and ask the client to leave. There had not been any incidents of violence in the last six months.

We examined three client care records and found that risk assessments had been completed for all clients. Clients were risk assessed prior to being accepted into the service. Risk assessments focussed on the following areas:

- risk associated with alcohol/substance use
- risk of suicide or self-harm
- risk of harm to others (including harm to clients, recovery staff, children and domestic violence)
- risk of harm from others (including domestic violence)
- risk of self-neglect

Information regarding risks was provided by the referring agency and other relevant organisations such as social services or probation. Risk management plans were completed as part of the admission process with the client. This included plans for unexpected exit from the service. Risk assessments and plans were reviewed monthly or following incidents.

There were a number of blanket restrictions that clients agreed to prior to admission:

- no mobile phones
- no access to restaurants or pubs
- no contact with family or friends for first four weeks
- no access to the local community unaccompanied
- all personal mail opened in the presence of staff
- no access to social media

The service was able to provide explanations for these restrictions, which were appropriate to meet the needs of the client group. However, they were not reviewed on an individual basis as clients progressed through their treatment programme.

All staff received safeguarding training as part of the induction training package. Further mandatory safeguarding training was available annually and all staff were compliant with this. Staff had access to a safeguarding flowchart to support them with reporting safeguarding incidents. Staff explained they would raise any safeguarding concerns immediately with a manager for advice or guidance. There was a safeguarding policy available to staff for reference. A safeguarding group met regularly to share good practice and information, evaluate response to critical incidents and review policies and procedures.

The service had a three stage medicine pathway to managing client medication. Clients were assessed prior to admission regarding which stage met their needs. The medicine pathway included:

- stage one involved medication being stored in a locked safe in the office. Clients were prompted to take their medication by staff. Staff monitored that medication was taken correctly and documented this.

- stage two meant that clients stored their own medication and self-administered with staff checking medication balances weekly.
- stage three involved clients self-administering and storing their own medication with no staff over-sight.

Clients were provided with lockable safes in their bedrooms for the safe storage of medication. Clients were responsible for the re-ordering of their medication and were prompted by staff when this was necessary. However, clients described difficulty accessing the GP surgery and one client missed their medication for two days due to problems communicating with the surgery. We discussed this with the senior management team who agreed to consider using an alternative surgery to avoid future problems.

Prior to admission clients were screened for parental responsibilities ensuring support was given to children whilst parents were undergoing treatment or were in the earlier stages of recovery. This met with the national society for the prevention of child cruelty's 'parents under pressure' initiative. Children were able to visit clients following a risk assessment and liaison with children's services if appropriate. If necessary staff could supervise child visits.

Track record on safety

There were no serious incidents or adverse events reported in the last six months.

Reporting incidents and learning from when things go wrong

Staff were familiar with the incident reporting system, which was available to all staff on an electronic system and in paper format. Staff gave examples of situations they would report and how they would record this and highlight incidents to the service manager. Information from incidents was shared with the quality and governance lead for critical review and feedback. Any feedback or trends were discussed in team meetings. There were up to date policies, procedures and guides to support staff to correctly report incidents. Incident reporting procedures were also discussed in team meetings. There was a system and process to ensure staff and clients received de-briefs following incidents.

Duty of candour

The service was in the process of finalising a duty of candour policy. A draft version had been produced in May 2017 and was awaiting board approval. The service endorsed an open and honest culture that was reflected in staff attitudes. Staff and managers were aware that mistakes should be apologised for and explanations given to clients as soon as possible.

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

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

We examined three care records, which demonstrated that thorough assessments were completed prior and during client's admission to the service. This included comprehensive drug and alcohol assessments, risk assessments and health screening. Records demonstrated that physical health care was assessed on admission and there was evidence of ongoing health care appointments during client's treatment.

Two recovery plans were completed to a good standard. They were up to date, personalised, holistic and recovery orientated. Recovery plans were developed in partnership with clients, their housing worker and counsellor to develop a personalised and individual plan. A copy of the recovery plan had been offered to clients and documented if this had been refused. However, one recovery plan had not been completed. The client had been admitted 12 days earlier and staff were planning to complete the recovery plan with the client on the day of the inspection. Another recovery plan had been completed six weeks after admission.

All client information was stored securely on an electronic system or within locked filing cabinets. Information was easily available to staff when needed.

Best practice in treatment and care

The service provided psychological based interventions in group and individual sessions. A dependency, emotional, attachment programme was used to explore addiction at a personal level. The dependency, emotional, attachment programme was based on therapies recommended by the national institute of health and care excellence guideline

51; drug misuse in over 16s: psychosocial interventions. This included psychodynamic therapy and cognitive behavioural therapy. This was delivered in a number of formats:

- one to one counselling
- trauma focussed groups
- attachment theory concepts explored in group therapy sessions
- psychodrama exercises
- aftercare group work
- family work

Clients were registered with a local GP practice as part of the admission process. Clients were encouraged to attend the GP service for any physical or mental health care needs. Clients were encouraged to be responsible for attending appointments but staff would prompt and encourage clients if necessary.

The treatment outcome profile rating scale was used to measure progress of clients before, during and after treatment. This information was shared with the national drug treatment monitoring system.

The service did not collate data to measure how many clients remained abstinent for 12 months following treatment. There were plans in place to conduct exit interviews with former clients beginning in August 2017.

Staff were involved in auditing of clinical records and other procedures. A volunteer had specific training and undertook routine audits of client's files and electronic client notes. Managers and staff together audited and discussed individual client records during supervision sessions. Managers completed audits of the building, training records, human resources information and environmental checks. There was a system in place for managers from other locations to audit the service to ensure impartiality and consistency. In February 2017, there had been an audit completed by another CQC registered manager and an external company had completed a health and safety audit. Information from audits was shared with the senior management team.

Skilled staff to deliver care

The service endeavoured to employ staff and volunteers who had previously been substance misuse clients. This meant that staff and volunteers would have greater empathy and understanding of substance misuse clients. Clients spoke of having great respect for staff due to this element and accepted advice and guidance from them more easily. Good peer support is a crucial factor as recommended by Public Health England, service user involvement, a guide for drug and alcohol commissioners, providers and service users. There was a high number of staff and volunteers who were ex clients within this service and 80% in the wider organisation. The counsellors employed were registered with the British association for counselling and psychotherapy and followed the appropriate standards and ethical framework.

All staff and volunteers received a four day induction training package that included the following modules:

- boundaries
- volunteer support
- introduction to the provider
- safeguarding
- confidentiality
- governance
- national treatment agency for substance misuse
- communication skills
- listening skills
- compliments and complaints
- health and safety
- equality and diversity
- activity

Staff had access to a wide variety of specialist training associated with their role. Staff had completed the following specialist training in the last six months:

- lone worker device training
- disposal of sharps
- passionate about customers
- lesbian, gay, bisexual and transgender awareness
- institution of occupational safety and health managing safely

- personal safety training
- health and safety risk assessment for managers
- overdose prevention
- self harm awareness
- personality disorder
- group work facilitation
- legionella awareness
- domestic abuse
- human trafficking
- corporate plan and values session

All counsellors were qualified to a minimum of counselling diploma level four. A senior therapist had a degree in psychology.

Managers actively encouraged further education and training within the workforce. At the time of the inspection, four staff were in the process of completing the following courses:

- degree in counselling (two staff/volunteers)
- NVQ counselling level two and three
- apprenticeship in health and social care level three (paid for by Calico Group)

Managers offered staff and volunteers placement opportunities where available and allowed staff time off to attend further educational training. Staff said they felt supported and valued by managers to develop their skills and knowledge. Staff were experienced in their roles and volunteers were well supported.

Supervision was provided in various formats:

- management supervision (six weekly)
- clinical supervision (six weekly)
- group supervision (six weekly)
- informal peer supervision (when needed)
- group de-brief (after each group session)

We checked the supervision records and found that over the last six months staff had been compliant with all aspects of supervision. Counsellors received individual external supervision.

A new appraisal system had been introduced. All staff had completed appraisals in April 2017. We looked at two appraisals and found they were meaningful and reflective of current and future achievements.

There were flash meetings held each day on Monday to Fridays, which all staff could attend. The purpose of the meeting was to discuss any matters arising for the forthcoming day. This included:

- named first aiders, fire wardens and on-call managers
- current safeguarding concerns
- building/housing issues
- lone working arrangements
- incidents

There were also weekly case management meetings where new referrals, admissions and potential discharges were discussed. Individual recovery plans could also be discussed in this meeting for guidance and support.

There was a system in place to address poor staff performance, which was documented in the capability procedure. This was a staged approach to managing poor performance. The capability procedure had not been implemented for any staff within the service. Managers were aware of how to support staff that were not performing and there were other policies aimed at avoiding poor staff performance. These included a stress management policy and a wellbeing policy. This was particularly important due to the high level of former substance misuse clients who were employed by the service and their particular vulnerabilities.

Multidisciplinary and inter-agency team work

All staff described good practice of reading all clients latest clinical notes prior to starting a new shift. Staff would highlight to each other any incidents or risks that were discussed in the daily flash meeting. Particular client concerns were highlighted in the daily flash meetings.

The service had good internal links with other aspects of the organisation such as supported housing and detox facilities. There were plans in place to strengthen links with the medical detox units and to share training programmes.

The service kept in close contact with referring organisations and other bodies regarding the progress of

each client. This involved the completion of a progress report at week ten of the 12 week programme. An end of treatment report was also produced and shared with referrers as part of the working partnership agreement.

The relationship with the local GP practice was not well established. Clients and staff reported difficulties with communication and obtaining repeat prescriptions and medical notes. During the inspection, the senior management team agreed to speak to the surgery and consider moving to a practice where substance misuse was better understood.

The service had strong links with third sector and mutual aid groups in the local area. This included a gardening project, a community gym, voluntary drug and alcohol services and a local chemist.

Good practice in applying the MCA (if people currently using the service have capacity, do staff know what to do if the situation changes?)

All clients' mental capacity to consent to treatment had been assessed as part of the assessment and admission process. Staff had received training on the Mental Capacity Act and deprivation of liberty safeguards as part of the induction and mandatory safeguarding training. Staff were able to describe instances were capacity might be in doubt, such as being intoxicated, and understood the relevant procedures. The service did not accept referrals for people with severe and enduring mental illness, learning disability or memory problems. This meant the likelihood of needing to use the Mental Capacity Act was minimal. Guidance relating to the Mental Capacity Act was contained within the safeguarding policy, which staff could refer to.

Equality and human rights

There was an equality, diversity and inclusion strategy that was up to date and included the Equality Act 2010. Equality and diversity training was covered within the induction programme for all staff. This included how to support people with protected characteristics. Staff could also refer to an equality, diversity and inclusion handbook that outlined the nine protected characteristics.

The parent company was awarded an accreditation for leaders in diversity by the national centre for diversity in 2014.

Management of transition arrangements, referral and discharge

Clients were referred to the service by local authorities nationwide. The service was on a nearby local authority framework agreement which meant people from the local area could be referred. The service also accepted self-referrals from clients who funded their own treatment costs. At the time of the inspection, there was one self-funded client.

On referral, the service completed a number of assessments based on information from the referring organisation and a face to face meeting with the client. If necessary, the service contacted other agencies for further information on risk and safeguarding concerns. The initial assessment process was completed by staff from a separate assessment team within the organisation. Staff based within the service had also been trained to complete assessments if needed. Following assessment, clients were invited to visit the service to meet with staff and other clients.

Being abstinent from substances was a prerequisite for admission to the service. Clients had completed detox programmes at services within the Calico group and other organisations. A detox provider had recently joined the parent company. There were plans to add detox centres to the treatment pathway making transition arrangements more streamlined.

On admission to the service, clients were introduced to key staff such as their counsellor and housing worker. The service ensured a senior peer was available to provide buddy support to new clients in the first days or weeks following admission.

Discharge plans were considered during the referral and admission process. The service had access to supported accommodation that was available to clients successfully completing the rehabilitation programme. The supported accommodation provided an eight week skills training for people in recovery programme. This included support with:

- relapse prevention
- education and training
- work experience
- wellbeing
- life skills

Substance misuse services

Following this programme, clients were assessed and supported to either move on to supported accommodation, (with less staff input) or independent living.

Other clients were supported to move directly from the service back to their home location or other independent living. This was done in conjunction with family support where applicable.

Are substance misuse services caring?

Kindness, dignity, respect and support

We observed a group therapy session attended by two staff and eight clients. The session included a client sharing their life story about the triggers for their substance misuse and how this was perpetuated and sustained by poor coping strategies and life choices. Staff were respectful of clients' feelings and views. Staff demonstrated an ability to challenge and confront clients regarding past behaviours in a manner that was both direct and non-judgemental. Staff gave each individual client opportunities to voice their views. There was a clear emphasis and culture of mutual understanding and shared experience. Peer support and responsive staff attitudes were embedded in the ethos of the group session.

Clients reported that staff were respectful and "go the extra mile to help". Clients felt that they could trust and relate to staff due to the high number of staff who were in recovery. Clients stated this gave them hope for the future and made recovery seem possible.

Client's individual needs were understood well by staff. This was ensured partly due to the small client numbers. This allowed staff to easily focus on client's needs. Staff were regularly kept up to date regarding client needs by daily flash meetings and a system of regularly reading client records. A robust assessment process also helped clearly identify particular client needs. Staff were able to demonstrate and discuss client needs and risks.

The involvement of clients in the care they receive

There was an admission process that allowed clients to familiarise themselves with the service before and during admission. This included:

- pre-admission visit to the service
- pre-admission face to face assessment
- informal discussions with clients prior to admission
- introduction to key staff prior to admission
- a senior peer to offer informal support following admission
- a tour of the local community following admission

Clients described feeling very much involved in their recovery planning and risk assessments. This was reflected in clinical notes and client feedback. Recovery plans were not always written in the first person. However, collaborative working was evident. Client records showed that clients were offered a copy of their recovery plan and it was documented whether this was accepted or declined. Maintaining independence was a key theme that was endorsed by the service. Clients were expected to take responsibility for most aspects of their daily care and living tasks.

Independent advocacy was available locally. Posters regarding advocacy were visible on noticeboards in communal areas. Staff were aware of local advocacy services and knew how to refer or signpost clients accordingly.

There was a weekly family and carers support group provided by the service. This included a rolling programme of formal support and education regarding substance misuse as well as informal support between families. Staff were trained to facilitate family and carer mediation. Clients were educated regarding the impact of their substance misuse on families and carers and encouraged to address their past behaviours. Families and carers were involved in the development of their loved ones care at an early stage in the treatment programme as well as at discharge. Clients were asked to consent for their families to be offered support. Carers reported that staff endeavoured to include them as much as possible and that information sharing was valued. Carers specifically highlighted the availability of staff to offer reassurance that was professional and honest.

There were weekly client house meetings. The set agenda each week included:

- client issues
- house issues

- staff issues
- maintenance and health and safety issues
- weekend plans
- shopping
- therapeutic
- what is working well?

We examined the minutes of these meetings and found that there were no re-occurring issues that had not been addressed.

There was a client suggestion box located in the communal hallway. Clients had made suggestions about possible day trips and other ideas regarding client comfort and privacy.

A client service satisfaction survey was due to be completed in September 2017, which would include both current and past clients. There have been no previous surveys due to the newness of the service.

Clients were encouraged to become involved in decisions about the service. A high number of clients became volunteers within the service and trained to become paid members of staff.

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

Access and discharge

The service accepted referrals nationally. However, the majority of referrals came from the local area and surrounding local authorities. This meant that clients living locally were more likely to have access to the service. The service accepted self-referrals and at the time of the inspection had one client who was self-funding.

Clients were moved to supported accommodation or discharged to independent living with the support of staff and volunteers. This was planned to ensure a safe and effective transition at the appropriate time for the client.

There had been no delayed discharges since the service opened in August 2016. Over the last three months, bed occupancy had been 100%.

The facilities promote recovery, comfort, dignity and confidentiality

The service had a sufficient number of rooms to facilitate activities and therapies. This included a group therapy room, a counselling room, two communal kitchens, a dining room and a communal lounge. However, there was no female only lounge. A female only lounge is required to allow vulnerable female clients an environment away from males who they may feel threatened or intimidated by. It was not feasible to have a female only lounge due to the layout of the building and the small number of residential clients. Vulnerable females were instead offered nearby accommodation within a domestic violence housing scheme with daily access to the therapeutic programme. Alternatively, day care treatment was also available for females able to travel from their own homes.

Clients could meet visitors within the building. Visits from family and friends were encouraged every Sunday. Visits could take place in the group room or counselling room. Clients felt the number of rooms was sufficient to support family visits.

Clients were not allowed mobile phones during the 12 week treatment period. Clients had access to a cordless office phone, which could be used in private in the counselling room, or clients own bedroom.

There was good access to outdoor space that clients could use at any time during the day. This consisted of a patio area that overlooked a stream.

Clients purchased and made all meals. There was a process in place for all clients to create meal plans and shopping lists. Each week clients were allocated a role such as cooking, cleaning bathrooms, kitchen work, vacuuming and budgeting. Clients worked together to cook communal meals for lunch and dinner. Clients described them as good quality.

Clients could access the kitchen at any time to make hot drinks or snacks.

Clients could bring items from home for their bedrooms. Clients were encouraged not to bring expensive items. This was to avoid ill feeling between clients and any risk of items being lost or stolen. Clients had a locked cupboard in their room where they could store valuables. Other items such as mobile phones were stored in a locked cupboard that only staff could access until discharge.

Substance misuse services

The service provided a range of daily therapies and group activities. These were facilitated within the service and within community settings. An average weekday consisted of:

- 9:30 daily check in (all clients give feedback and updates on how they are feeling and any problems arising)
- 10:00 – 12:30 activating events, beliefs, consequences and disputes diaries
- 13:30 – 14:30 psychodrama expressive therapy
- 15:00 – 16:00 group de-brief and learning outcomes
- evening, completing household chores, homework from group work and external mutual aid support groups.

There was no fixed structure to activities arranged at weekends. During the week, clients planned a group social activity in the local community to take place on Saturdays. There was an expectation that all clients should attend. Clients could choose anything from sports activities to day trips to other local towns. On Sundays, clients were available for family and friends to visit. Clients were reminded that social isolation endangers recovery. Clients were offered advice and guidance on how to successfully occupy their time. There was a caretaker available to support clients if necessary.

Meeting the needs of all clients

The building consisted of four floors, which were not accessible for wheelchair users. There was no lift or accessible bathrooms. Clients were assessed prior to admission regarding any disabilities or mobility problems. Physical health needs were considered before a placement was offered to clients. Clients with physical health needs were offered placements at other Acorn facilities where their needs could be met.

Clients were given a welcome pack on admission to the service. The welcome pack contained information on independent advocacy, complaints and compliments. If necessary, leaflets and materials could be produced in other languages and formats such as easy read. For clients with hearing difficulties or non-English speakers a British sign language translator or English translator was available on referral to language agencies. However, the senior management team felt the needs of the individual client would need to be balanced with the needs of the group.

Vulnerable clients were identified via the assessment process. This included clients who were victims of domestic abuse and homeless people. The service employed a housing support worker to specifically look at housing options in the short and long term. There were strong links with domestic abuse support services in the local area.

Clients were provided with information about treatment programmes prior to admission. Clients were given a choice of treatment options, which included 12 steps treatment programme or dependency emotional attachment programme. There was also a choice of locations and the option for residential treatment or day care treatment. Information about treatment options was discussed with clients during face to face meetings and in leaflet format. Clients were given information regarding other local services from staff, volunteers and other clients. New clients were given a tour of the local area to ensure clients were aware of where other local service were.

Particular dietary requirements could be met by the service. Clients were responsible for the planning, ordering and cooking of meals. Clients with special dietary needs could request certain foods be included on the shopping list. Dietary requirements were discussed within weekly client planning meetings. More specialist food such as Halal could be ordered from a food supplier which staff would support clients to access.

Spiritual support was available within the local community. Staff were aware of local churches and mosques where clients could attend. Clients were supported to attend spiritual support by staff or other clients.

Listening to and learning from concerns and complaints

There had been no complaints about the service since they opened in August 2016. Clients were aware of how to complain and there was a suggestions book which clients could express opinions about the service. We reviewed the suggestions book and found that clients had made suggestions about day trips and ideas to make their stay more comfortable such as fans in hot weather. Clients reported suggestions were responded to informally.

Substance misuse services

Staff were aware of the complaints process and how to escalate concerns to a manager if appropriate. There was a complaints policy and procedure in place outlining how to handle a complaint. This was available to staff electronically.

The complaints process included a three stage approach to managing complaints

- stage one – informal or minor complaint with prompt resolution. Investigated within one day and a report shared with managers and quality assurance lead
- stage two – complaints not resolved under stage one and any other serious complaint. investigated within 10 working days
- stage three – appeals process

Are substance misuse services well-led?

Vision and values

The service was part of a parent organisation whose aims were:

- to be customer led in delivering excellent services
- to create social profit for the areas where we work
- to provide value for money in everything we do
- to secure and deliver new business opportunities and partnerships
- to realise people's full potential

The values of the parent organisation were:

- going one step further with our customers
- improving and strengthening ourselves and our organisation
- our wellbeing as individuals and teams

The service had developed aims particular to substance misuse rehabilitation, which were "to enable individuals and their families to break free from drug, alcohol and other addictions by providing a range of innovative recovery services." Staff were aware of the vision and values of the service.

Staff displayed a positive and committed approach to clients care. Staff were energised about improving the lives of others and demonstrated the possibilities of achieving this. Many staff and volunteers were in recovery and were focussed on developing long term solutions for recovery. Staff had a clear vision for the future of clients and the service that matched the aims of the organisation.

There was a programme in place which allowed the chief executive to visit all of the services within the company. Staff described senior managers as approachable and transparent. Staff were invited to a listening group every six months to raise any concerns. Staff were aware of senior managers and their individual roles and responsibilities.

Good governance

There was an effective system in place to ensure that all staff and volunteers had received and were up to date with mandatory training, supervision and appraisals. Managers had oversight of supervision, appraisals and staff training records and discussed training needs during supervision sessions. This information was shared with the operations manager, human resources, senior management team and directors. Regular audits were also completed and fed into this information stream.

The service ensured there was always a member of staff on duty at all times. This was achieved by having a live in care taker and a staffing rota that was developed to accommodate 24 hour care. There was access to voluntary staff to supplement the permanent staff members.

Many staff had lived experience of substance misuse and were in recovery. This meant the workforce was highly experienced and motivated to encourage change and rehabilitation. The senior management recognised this and endeavoured to facilitate formal learning to compliment lived experience.

The service had a weekly timetable of activities that allowed staff to focus on direct care with clients. The timetable incorporated other social or life skills activities that allowed staff to have time to reflect on client care and complete any administrative duties.

The provider had a list of key performance indicators that were submitted to the company board each month. Key performance indicators included:

- number of clients completing treatment
- number of clients in active treatment

- number of clients unexpectedly exiting treatment (reasons for exit and number of weeks into treatment)
- number of clients who have previously accessed other rehabilitation (number of clients completing treatment and retention rates)

Information was also reported to the national drug treatment monitoring system. The service was aware of issues such as falling referral numbers which was reflected nationally. The senior management team were considering increasing the availability of cheaper day care treatment programmes.

The service had a three year plan with a number of targets to be achieved by 2019. These included a range of growth and financial aspirations and targets.

Leadership, morale and staff engagement

The service had negligible sickness and absence rates. Staff reflected this was due to the supportive work environment being embedded in the service. There was a team approach and shared responsibility which reduced stress levels. Staff described being sent for external counselling for particular issues which minimised any possible sickness or absence.

There had been no bullying or harassment cases since the service opened in August 2016. There were policies and procedures to address bullying and harassment. There was a whistleblowing policy and staff were aware of how to instigate this.

Staff described feeling confident in their manager and senior managers. Staff explained how they raised a concern during a team meeting which was listened to and discussed. This resulted in managers and staff addressing the concern by arranging extra drug testing training. Staff can now contact the drug testing company directly for advice. Clinical practice regarding drug testing was improved.

Morale and job satisfaction were high throughout the service. Staff were enthusiastic about their work and proud of what they achieved. Staff felt valued by the service and that their wellbeing was taken seriously. The parent company had provided dance lessons for 5 months for staff nationally in order to compete in a company dance competition in Blackpool. All staff were invited to attend.

Opportunities for leadership training for managers were widely available. The manager's internal training programme included:

- managing absences
- conflict management
- appraisal training
- supervision training

Other training was available such as motivational training and workplace coaching. Managers had access to regular learning lunches where topical discussions took place regarding managerial issues.

Commitment to quality improvement and innovation

The service had successfully renewed and widened its contract with a local authority. This involved broadening community based substance misuse services within the local area. The senior management team were proactive in addressing the nationwide reduction in funding for residential substance misuse treatment. A nearby service had closed and staff redeployed to Bank Parade or other housing projects. There had been an expansion of the day client service at Bank Parade which provided different pricing options to commissioners. The service will also be able to focus on resettlement and outreach support for clients moving on to independent living following treatment.

The parent company had been awarded the following recognitions and accreditations in the last 12 months:

- best companies 2017- 2 star organisation
- housing quality network: direct labour organisation accreditation
- investors in people gold award
- commitment award – the workplace wellbeing charter
- apprenticeship good for our business
- telecare service association – the voice of technology enabling care
- equality and diversity- chartered institute for housing: charter for housing
- disability confident employer
- mindful employer

Substance misuse services

- contractors health and safety assessment scheme accredited contractor
- building for life – silver award
- housing diversity network

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that blanket restrictions are reviewed on an individual basis and at regular intervals throughout the treatment programme.
- The provider should ensure that recovery plans are completed in a timely manner.