The Bridges

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 provide safe care and treatment to clients.
- The service kept a stock of naloxone medication on site for use in emergencies.
- Clients received care and treatment underpinned by best practice.
- Patients had up to date care plans that were holistic, personalised and recovery oriented.
- The service had established links with mutual aid and recovery support agencies in the community.
- The service had high client completion of treatment rates.
- We saw positive and respectful interactions between staff and clients.
- Client involvement was central to their recovery plan.
- The service provided a structured activities plan for every day of the week.
- The service provided ongoing aftercare and support to clients following completion of treatment.
- There were established system and protocols in place leading to the effective management of the service.

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

Summary of findings

- Soft furnishings and decor needed either replacing or refurbishing in certain areas and some repair work to the building was needed .
- Staff did not always consider wider risks to the community when assessing client risk.
- The service did not inform the Care Quality Commission of those incidents that gave rise to a notification.

Summary of findings

Contents

The Bridges

Services we looked at
Substance misuse services

Summary of this inspection

Background to The Bridges

The Bridges is a residential service provided by The Rehabilitation for Addicted Prisoners Trust, a registered charity. The service provides an abstinence based drug and alcohol treatment programme for men aged between 18 and 65 years referred by the probation service from prison. It is registered with the Care Quality Commission to provide accommodation for persons who require treatment for substance misuse. The Bridges has a registered manager and a nominated individual.

The service is located in a residential area of Hull. It is close to local amenities and has good access to public transport and the city centre. The service is able to take up to 16 men at any time and has staff on duty 24 hours. At the time of our inspection, the service had 10 clients, seven in primary treatment and three in the second phase. All clients have to be free of any substance use and produce a negative drug test before admission. This means they will have undergone a detoxification programme before their release from prison. The Bridges does not offer clinical or prescription medicine treatments. It provides a programme of psychosocial interventions and a therapeutic environment to support recovery from addiction. The Bridges accepts admissions from the National Probation Service Humberside and self-funders.

The Bridges has been working with offenders with an alcohol and drug addiction since 2004. Clients take part in a therapeutic programme based on the 12-step principles of Alcoholics Anonymous and Narcotics Anonymous. The 12-step approach works sequentially as a process to guide a person through the journey of recovery to a new way of life. The programme addresses the physical, mental, emotional and spiritual aspects of recovery. The principles behind this approach give a person a starting point for a lifelong process. All aspects of The Bridges follow the ethos of the 12-step approach with two distinct treatment phases.

The premises comprise eight single occupancy rooms for clients undergoing the first phase of treatment and eight self-contained flats for clients who progress to the second phase of treatment.

The hepatology department from the local hospital attended the service once a month to support clients who had acquired a blood borne virus through their addiction.

A family support service attended once month to help clients build bridges with their families. The provider in partnership with another local service jointly ran this family support service.

The Care Quality Commission previously inspected this service on 5 December 2012 against the former outcomes. The service was meeting all the requirements against the following standards:

- Treating people with respect and involving them in their care
- Providing care, treatment and support that meets people's needs
- Caring for people safely and protecting them from harm
- Staffing
- Quality and suitability of management.

We carried out this inspection using our new approach of asking five key questions about the quality of the service. See the section on 'How we carried out this inspection' below.

Our inspection team

The team that inspected the service comprised Care Quality Commission inspector Jacqui Holmes (inspection lead) and two other CQC inspectors.

Summary of this inspection

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, asked other organisations for information.

During the inspection visit, the inspection team:

- visited both units at this location, looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with six clients
- spoke with the registered manager and the service manager
- spoke with three other staff members employed by the service provider, including the team leader and key workers
- received feedback about the service from stakeholders
- spoke with three graduates (clients who had successfully completed treatment)
- attended and observed a daily community meeting for clients
- collected feedback using comment cards from two clients
- looked at six care and treatment records for clients
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with six clients about their experience of the service and received very positive feedback about the emotional and practical support they received from staff. Clients said staff listened to them and took time with them when they needed it. They felt staff treated them with courtesy and respect.

Feedback from funders was equally positive. One funder praised communication and the client centred approach provided by the service. The only negative comment was in relation to the environment, which described the building itself as old and not aspirational in terms of premises fit for recovery. The clients themselves did not give any negative feedback about the service or the environment.

We arranged for a comments box to be placed in the service ahead of the inspection. We received two comments, both praised the professionalism and caring nature of staff.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

We found the following issues that the service provider needs to improve:

- Refurbishment and replacement of soft furnishing were subject to a three year rolling programme regardless of their existing condition. The cleaning and removal of stains to carpets and redecoration of rooms and corridors that were in need of an update were not actioned in a timely manner.
- Staff did not always consider wider risks to the community when assessing client risk. They concentrated on how they would manage the risks within the service.
- The service did not inform the Care Quality Commission of those incidents that gave rise to a notification.

However, we also found the following areas of good practice:

- The service had enough staff to provide safe care and treatment to clients. They prioritised any group work timetabled and ensured this went ahead if there were unexpected staff absences.
- Staff had been trained in the use of naloxone, which is a medication used to reverse the effects of opiate overdose. The service kept a stock of this medication on site.
- The service had a strong link with a local GP. New clients registered there and received a health check within a week of starting their treatment with The Bridges.
- Clients had early exit plans in place if they left the service before completing treatment. These ensured staff discharged clients in a safe manner, minimised the risk to the client and complied with any probation or licence terms.

Are services effective?

We found the following areas of good practice:

- Clients received care and treatment underpinned by best practice, and had access to psychosocial therapies, group work sessions and individual one to one sessions with a counsellor.
- Clients had comprehensive assessments and care plans, which were detailed, holistic and recovery focused. They identified substance misuse, emotional and social needs.

Summary of this inspection

- Staff had regular supervision and ongoing appraisals of their work performance from their manager, giving them the support and professional development needed to carry out their duties.
- The partnership arrangements ensured a multidisciplinary approach. Interagency work with the local recovery community and mutual aid provided clients with further support, activities and training. Staff had formed effective working relationships with external agencies to support clients during and after their rehabilitation.
- The service had high client completion of treatment rates. In all, 94% of clients successfully completed treatment between 1 April 2016 and 31 October 2016.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients reported positive interactions with staff and praised them for being caring and respectful. They appreciated that staff were always available to offer them support on an emotional level as well as practical.
- Staff displayed in depth knowledge of their clients' needs and made appropriate referrals to external agencies to support them further.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Discharge planning included an ongoing aftercare package to support clients following rehabilitation. Graduates were encouraged to join the provider's graduate programme and become involved with supporting clients undergoing the same treatment.
- Clients had structured treatment plans, with activities taking place every day of the week.
- Clients knew how to raise complaints formally and informally. The reported that staff dealt with complaints in an efficient and effective manner, keeping them up to date with progress made.
- Staff adapted treatment materials and information to meet the needs of those clients who had literacy issues. They provided support and encouragement to improve literacy levels when needed.

Are services well-led?

We do not currently rate standalone substance misuse services.

Summary of this inspection

We found the following areas of good practice:

- Systems and processes were in place to ensure the service manager was able to monitor the quality of care and treatment provided. Local and national audit results fed into staff supervision. Investigations from incidents led to lessons learned and innovations in the service.
- Staff were committed to providing recovery focused care and valued the support and guidance they received from colleagues.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act formed part of mandatory training. Staff assumed clients had capacity and understood the basic principle of the Act. They understood when capacity was temporarily impaired and were clear on what actions they would take if this was the case.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

Staff and clients told us that they felt safe at the Bridges.

The building environment and facilities were old and careworn although the communal areas were comfortably furnished. Clients discussed repairs and maintenance issues at their daily community meeting, which staff then recorded in the maintenance log. The service was reliant on the provider for remedial works such as the window in the upper lounge, which was decayed and required attention. We noted staining to the carpets in eight rooms and the décor of upper level corridor and four of the bedrooms needed updating. The remaining bedrooms were clean and adequately maintained. Toilets and bathrooms were clean and there were no infection control issues. We saw the service had recently replaced some beds and staff told us they provided clients with new bedding including quilts upon admission. There was a renewal programme for facilities within the service

To ensure The Bridges provided an environment where clients felt safe from their addictions, clients agreed to a treatment contract before their admission. The contract set boundaries and conditions, defined a code of conduct and stated an expectation for each client to be involved in the daily tasks for running the house.

For example, clients had access to the laundry room on a rota basis and it was their responsibility to keep their bedding, including duvets and pillows clean. This was all part of their recovery plan. Clients attended a morning meeting where they could raise any issues they were having with their laundry. We saw the client rota for the laundry and noted the manager regularly checked that clients had done their laundry and cleaning.

Clients used the commercial kitchen on site, which was clean and functional. All clients who used the kitchen were aware of food hygiene and were able to tell us which food preparation boards they used with which food groups.

The service devised a treatment contract to work alongside the initial steps in the 12-step programme. This helped clients regain control over their addiction and compulsive behaviour and concentrate on their recovery with minimum distractions.

All staff completed first aid training as part of their induction, which enabled the service to have a first aider on site at all times. In addition, the service had all staff trained in life support to administer naloxone in emergencies. There were fire instructions displayed around the building informing people what to do in the event of a fire. The service had invested in updating and replacing their existing fire alarm systems and work was due to commence shortly. All staff, clients and visitors signed in and out of the premises. This meant that if a fire did occur staff could quickly check that everyone had evacuated the premises.

Safe staffing

The service had recently undergone a management restructure. There was 11 substantive staff in total, including the service manager and team leader. In addition, the service had four active volunteers and at least one graduate attending on a daily basis. A graduate was a client who had successfully completed the treatment programme at The Bridges. Graduates were able to champion what opportunities recovery could bring and provided a mutual understanding in their recovery journey. The service covered any shortfalls in staffing using the existing staff team or employees that worked for the provider in another service. There was one staff vacancy, which the service had just filled .Staff sickness in the 12 months prior to the inspection was 4.1%, which was comparable to average

sickness rates in the NHS. There was no one on long term sick; however, the service had an increase in staff sickness levels during September, which led to the registered manager submitting a request for one extra counsellor.

Three staff had left during the same period but no clear themes for staff moving on emerged.

Staff and clients told us that the service never cancelled groups or therapy sessions. Staff would rearrange their duties to ensure groups went ahead during unexpected staff absences.

One member of staff was present during the evening and overnight. There was an on-call rota, whereby a keyworker or manager could attend if necessary, to support them. A manager was always available for advice as required.

All staff completed aspects of mandatory training as part of their five day induction to the service and received refresher training as required. Staff received training in:

- quality and safety
- equality and diversity
- boundaries and confidentiality
- recovery pathways
- wellbeing and resilience.

Additional mandatory training included first aid, fire safety, safeguarding children and adults, and the Mental Capacity Act. Compliance with safeguarding adults and the Mental Capacity Act was below 75%. Staff who had not completed this training were awaiting training dates. The impact on the service was minimal as staff discussed any safeguarding or mental capacity issues with line managers in the first instance and as a team.

Assessing and managing risk to clients and staff

Staff assessed clients on admission to the service and used this process to identify client risks. The assessment paperwork prompted the staff to explore risks around physical and mental health. However, it did not prompt staff to consider those risks relating to domestic violence, debts, self-care or conflicts with others. The service relied on the skills of the counsellor and the referrer's risk summary to identify these risks. Staff completed a risk management plan detailing how they would mitigate each risk identified.

We looked at six client records all of which included risk information provided by the referrer prior to admission. All six records had up to date risk management plans, which staff from The Bridges had completed. There were omissions in the risk management plans. For example, one client had lapsed in their drug use while outside the service and staff had not reflected this in the risk management plan. However, case notes did detail the actions staff had taken to prevent re-occurrence. Staff also used the daily handover meeting to discuss risks and a communications book to update colleagues not on shift.

Staff reviewed the risk management plans regularly. They did this by adding updates into the previous risk management plan. This meant that staff might only be reviewing previous risks rather than fully assessing to establish if there are new risks.

Of the six records looked at, five included plans which the client had agreed with regarding what actions should be taken if the client left the service in an unplanned way. This was essential due to the criminal justice element of the client's placement. The service would contact the client's funder or probation service as necessary to ensure steps were in place to keep the person safe and comply with any legal requirements.

In the files we looked at, there was one occasion where staff had evidenced that they had discussed harm reduction with the client. Staff we spoke with all mentioned harm reduction information was part of the recovery plan although they had not documented this in clients' notes.

The Bridges reduced risks relating to a client's drug or alcohol use by imposing conditions in the treatment contract. These clearly stated that a client would live within their means and not receive regular additional income from external sources or frequent risky environments such as pubs, clubs and gambling institutions. Staff discussed prohibited items that might affect client safety or recovery with their clients prior to their admission. This information was available on their website and in the induction booklet given to clients as a reminder. These items included energy drinks, clothing with inappropriate logos and medical and dental preparations containing alcohol. On admission, staff searched clients' bags in their presence to ensure they had not brought in banned items.

Substance misuse services

Staff received training in safeguarding and knew how to make a safeguarding alert and share concerns with team members. The service had made no safeguarding alerts in the 12 months prior to our inspection. Clients' involvement with social services formed part of the referral information.

All clients admitted to The Bridges were required to be sober and not using any illicit substances. The service did not admit clients undertaking an alcohol detoxification regime or anybody prescribed medication as a substitute for heroin use. However, the service had piloted a trial in the 12 months prior to the inspection, where the service admitted clients nearing the end of an alcohol detoxification. Responsibility for the safe completion of the detoxification remained with the service who initiated it.

On admission day, clients were drug tested using a full drug screen, which included a test for 'spice'. This is a man made, mind altering chemical that some clients manage to access but would not form part of any detoxification process. This ensured clients coming into the service were drug free.

Staff breathalysed clients on a daily basis and carried out drug testing two or three times a week, including ad hoc testing. We saw staff followed infection control procedures for the administration and disposal of these tests. The service stored the medicine naloxone on site and staff had undertaken training in administering it. Naloxone is a drug used in emergencies to reverse the effects of a heroin or opiate overdose.

Staff referred all clients to a local GP, who would prescribe any other medication. The Bridges generally did not accept any clients prescribed benzodiazepines or codeine based medications because of their addictive qualities. Staff would consult with Rehabilitation for Addicted Prisoners Trust's clinical director for guidance if necessary.

Before admission, clients agreed to staff storing and issuing their medication when it was required. All staff received training to support clients taking medication. Staff issued prescribed medications in line with the medicines administration procedures of the service. Staff kept records for all their clients, with systems in place for medicines reconciliation and audits.

The service has a lone-working policy and lone workers carried a personal alarm and phone. The alarm linked directly to the police. The service had external close circuit television to help keep the building secure and to protect the residents.

Track record on safety

The service had five incidents between December 2015 and June 2016, which they considered serious enough to merit an investigation. On inspection, we determined that the service should have notified the Care Quality Commission about two of the incidents. Following a recent inspection of a different service, the provider had made the registered manager and the service manager aware of those incidents that gave rise to a notification. Consequently, the service had started notifying the Care Quality Commission of all incidents it was required to.

Reporting incidents and learning from when things go wrong

Staff followed the provider's incident reporting policy and procedure. Staff showed a good understanding of what they needed to report using internal processes. This meant the provider had a formal system to investigate and share any learning with staff and was able to identify any themes or trends that needed addressing. Incidents reported included client aggression, medication errors and staff falls.

Staff told us that investigations took place and managers shared any lessons learnt in team meetings and during handover. One example of learning led to staff receiving overdose training and keeping naloxone on site.

Duty of candour

The service had a duty of candour policy and managers were aware of their responsibilities under this. The staff team took ownership of their actions and promoted an ethos of openness and transparency.

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

Assessment of needs and planning of care

The Bridges took male clients of working age. There was an expectation that clients arrived at the service abstinent with the goal to remain so. Staff carried out assessments prior to admission considering a person's realisation of

abstinence as part of the process. Assessments were face to face wherever possible, however many clients were referred from prisons. In these instances, or where distance was a factor, staff carried out the assessment via the telephone. Staff reviewed the assessment on admission when they could speak with clients face to face.

We looked at six client records. All records included an initial assessment where staff considered previous drug use, physical health needs, mental health, previous treatment experiences and motivation to change.

The Bridges had a good relationship with a local GP. New clients registered with the GP and received a full health screen within one week of admission. Clients then took responsibility for managing any physical health concerns through their GP. Staff we spoke with knew the pathways involved to access specialist medical care. They could identify through observation and comments made by other clients if a client needed support with either their physical or mental health.

Records showed that staff continued to assess a client's mental health once admitted. They used detailed organisational assessment tools, which looked into all aspects of clients' mental health in detail. Staff had good relationships with the community mental health team. For example, staff were able to assign a community psychiatric nurse to a client prior to their release from prison in advance of their arrival at The Bridges.

Clients worked with staff to set their own recovery plan. The service used a recovery outcome star, which enabled clients to identify areas of their lives, which need improving. These included self-care, living skills, social networks, relationships, self-esteem, trust as well as their addictive behaviours. This then formed their recovery plan.

The client records we looked at included a plan for their recovery with goals reflecting personal areas for improvement. Each goal detailed actions required in order to achieve the goal. There was some inconsistency as some of these actions were specific in detail, for example, for a client to complete a housing referral. Other actions were more generalised, for example, to help a client reflect.

Clients signed and dated each individual goal and staff offered copies of the plan to the clients on all occasions. Staff regularly reviewed the plans with clients. This included reviewing previous goals and noting reasons why clients had not achieved goals if this were the case.

All client information needed to deliver care was stored securely and accessible to the staff when they needed it.

Best practice in treatment and care

As an organisation, the provider had a research team who ensured their services followed the latest best practice in treatment and care. They held an annual conference, conducted quarterly management meetings and emailed weekly staff bulletins to communicate the latest developments and requirements. For example, this included strategies relating to new psychoactive substances and guidance from Public Health England.

The National Institute for Health and Care Excellence guidance on alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (reference CG115) recommends that clients have access to mutual aid support groups such as alcoholics anonymous. Mutual aid relates to treatment that occurs outside formal treatment settings and offers locally derived peer support networks. The alcoholics anonymous fellowship developed the 12-step approach used by The Bridges. The service had access to mutual aid groups, which included alcoholics anonymous. Clients attended the appropriate external group as part of their treatment.

Alongside this12-step approach, the service also used evidence based research such as elements of motivational enhancement therapy and the seeking safety approach. Seeking safety was a counselling model to help people address trauma and addiction.

The Bridges incorporated findings from Project Match into their service delivery. Project Match was an American study sponsored by the National Institute on Alcohol Abuse and Alcoholism to determine how different types of alcoholics respond best to which treatments.

In two out of the six records we looked at, we saw evidence where staff used node link mapping to deliver psychosocial interventions. Node link mapping is a technique recommended in Public Health England's "Routes to Recovery" guide. This provides a simple way to present verbal information in the form of a diagram, which has positive benefits for key working.

The Bridges were able to monitor their performance nationally. Staff completed periodic treatment outcome profiles for the clients. This information reports into the National Drug Treatment Monitoring Service. The National

Substance misuse services

Drug Treatment Monitoring Service collects, collates and analyses information from and for those involved in the drug treatment sector. Public Health England manages the National Drug Treatment Monitoring Service; producing activity reports for providers to give a full picture of residential rehabilitation activity nationally.

Clinical audits took place across the service. The team leader carried out monthly reviews of client case files and observed staff during one to one sessions with clients. Staff used the findings from these audits in supervision to improve practice. The organisations governance team also conducted a full annual service review.

Since April 2016, the service had 21 clients enter treatment with 19 clients successfully completing the programme.

Skilled staff to deliver care

Staff had the necessary skills to deliver care effectively. The staff team included staff that had attained a minimum level three in counselling skills. However, although not a pre-requisite of employment, the team also included one registered counsellor and staff with accreditations above the required minimum. New employees, including administrative staff, completed a five day induction.

Staff were able to participate in additional specialist training. One staff member was in the process of completing a cognitive behavioural therapy degree and the manager was undertaking an accredited management course.

Staff told us they received regular supervision and a yearly appraisal. The organisational policy expected staff to receive supervision either two weekly or four weekly that lasted between one and two hours in duration. Staff compliance with supervision targets was 67 %. However, staff received support on a daily basis from the team leader. The provider's governance team were considering a proposal to reduce the frequency of supervision. Supervision is a tool managers use to support and develop staff to provide good standards of care and treatment. In addition, staff had access to external counselling to support them in their counselling role.

Multidisciplinary and inter-agency team work

Staff attended a daily handover meeting where they discussed each client's progress, updated any risks and daily activities taking place. Staff who were not on duty referred to the communications book for their update.

The Bridges had an established joint working protocol with the National Probation Service in Humberside and were an approved address for people leaving custody. They had strong links with local housing providers, Hull City Council housing department and other recovery support networks that provided ongoing care to meet the holistic needs of clients.

The service provided client's funders with updates at agreed intervals. These meetings included the client and the client's keyworker for part of the discussion. One funder informed us that communication was excellent and that staff at the service involved them in some decisions regarding the client's treatment and care.

Adherence to the MHA

The service was not registered to accept clients detained under the Mental Health Act. If a client's mental health were to deteriorate, staff were aware of whom to contact.

Good practice in applying the MCA

Staff received Mental Capacity Act awareness training as part of mandatory training. They received refresher training every three years. Their current compliance rate with this training was 73%, however three staff were waiting for further training dates to be released. Staff were aware of the basic principles of the Act and always assumed that a client had capacity. They told us they would recognise any temporary impairment of capacity and would discuss any ongoing concerns regarding a person's capacity as a team and refer onwards if this were required.

Equality and human rights

The provider's policies and procedures referred to the nine protected characteristics contained in the Equality Act 2010 – age, disability, gender reassignment, marriage and civil partnership, race, religion or belief, sex, sexual orientation, and pregnancy and maternity. The provider removed any potential bias when shortlisting applicants for jobs within the service, by removing any identifiable characteristics. All staff received training in equality and human rights during their initial induction to the service.

Are substance misuse services caring?

Kindness, dignity, respect and support

Substance misuse services

The service had a friendly and upbeat atmosphere, which led to ease of communication and positive interactions between staff and clients. Staff had clearly developed a therapeutic relationship with their clients and this was evident in their approach and the way they treated clients with respect. We observed clients to be relaxed and well supported, with staff showing an in depth understanding of individual needs and providing daily structure in their treatment. Clients we spoke with said staff were supportive both emotionally and in a practical way.

Staff respected confidentiality. There were clear information sharing agreements in place between the client and the service. Clients signed consent forms specific to each agency or person with whom the service wanted to share information. Clients could withhold their consent in which case staff respected their wishes.

We spoke with three graduates about their experience of the service. They told us they all had named counsellors and found staff would always make time for them if they needed to discuss anything. One graduate praised the service for being very person centred and peer led. Other clients confirmed this throughout the day.

The involvement of clients in the care they receive

Prior to admission, prospective clients engaged with staff and received information about what treatment at The Bridges involved. All clients received an induction pack and client handbook on admission. This provided them with information around admission procedures, terms and conditions for their stay, rules, the programme, rights, guidelines, and details of how to make a complaint, disciplinary procedures, confidentiality and safeguarding. Staff assigned new clients a peer as part of a 'buddy' system to orientate them with the routines of the service.

We spoke with six clients who said the service placed them at the heart of planning their treatment and care and did this with support from their named counsellor. We received feedback separate to the inspection that confirmed this approach. Care plans reviewed during the inspection reflected a person centred approach.

We saw the IT suite available to the clients. Clients had access to a software application that allows a person to have a spoken conversation over the Internet usually with viewing by webcam. This allowed clients to retain contact with their family and friends. In some cases, it helped clients to establish contact with their families.

Clients were encouraged to access and work with a family support network run by the provider in partnership with another service. This helped clients resume contact and build bridges with their families.

Clients told us the counsellors and support workers worked with them to access voluntary jobs whilst in rehabilitation and to help sort out any housing, or benefit issues.

Clients attended a weekly community meeting, which was client led with counsellors offering support.

During the meeting, all clients discussed their compliance with the treatment contract they had agreed to on admission. Clients were able to challenge each other's compliance, set consequences and offered ideas and advice on how they could improve compliance. The counsellors only offered advice when they felt the clients were being too hard on themselves or each other or setting unrealistic consequences. Clients were also encouraged to identify any issues they had with their environment so that staff could arrange to fix them.

Clients attended a quarterly meeting, which provided an opportunity for clients to feedback any concerns or suggestions to management. Clients were also able to comment on their care during their treatment reviews and through exit interviews. We saw the service displayed minutes from previous meeting on the notice board so that everyone could see them.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Access and discharge

The Bridges admitted clients from prisons and community treatment agencies both locally and nationally. All offers of treatment were subject to approval from the National Probation Service Humberside and written confirmation of funding. Once funding was in place, the client transferred from their probation service into Humberside probation who managed the conditions of their placement. The Bridges had regular referrers that knew their criteria; this meant that the agencies making the referral had an understanding of the treatment offered and could discuss it with their client. The Bridges also accepted clients who referred and funded themselves. Staff coordinated

admissions with prison release dates, and provided a meet and greet service. They met clients either at the railway station if they were not local, or at the prison gates upon release.

Referrers generally funded a person for an initial 12 weeks. However, the service was flexible agreeing shorter or extended treatment options dependent on the funder's requirements. Staff conducted an assessment interview for all referrals prior to admission. In some circumstances, staff arranged face-to-face assessments and visits by prospective applicants. The service usually made offers of treatment within two weeks of the assessment, provided Humberside Probation accepted the transfer of the client and funding approved.

The Bridges did not generally accept clients who:

- had a history of arson
- had a conviction of an offence listed in the first schedule of the Children and Young Persons Act 1933.This list includes serious offences such as murder, manslaughter assault, cruelty and a range of sexual offences.
- experienced mental illness and a substance abuse problem at the same time (this is known as dual diagnosis).

This was not a blanket ban as the service did consider certain cases where they considered the risks low and historical.

Preparation for the client's discharge and integration into the community began at the induction stage. Resettlement was an integral part of the treatment plan with a strong focus on finding accommodation for those clients of no fixed abode. Every client worked with staff to ensure they had secured suitable accommodation for when their treatment ended with 95 % of clients moving onto independent accommodation.

The service provided free ongoing aftercare for those men who lived or relocated to the Hull area and for those based in the London area through the Rehabilitation for Addicted Prisoners Trust graduate support network. Staff and graduates told us that The Bridges gave ex-clients the opportunity to refresh their recovery approach if needed.

The facilities promote recovery, comfort, dignity and confidentiality

The Bridges was located in a busy residential area of Hull with easy access to mutual aid groups, the city centre and local amenities. The building provided adequate accommodation. Bedrooms were basic and bland; however, the communal spaces were comfortable and warm. There were sufficient rooms available to provide the scheduled activities. Clients spent the first phase of their treatment living in the bedsit accommodation, which encouraged a sense of community and ensured support was readily available. During the second phase of treatment, the emphasis was on developing and progressing towards independent living and clients transferred to a flat within the main building. This gave them the opportunity to be responsible for the running costs and maintenance of the accommodation.

Staff provided a structured and full timetable for clients. This included various group sessions, one to one sessions, external trips, household chores and time scheduled for individual homework. Activities continued into weekends. We observed a community group that encouraged involvement from all clients.

During the first phase of treatments, staff and volunteers supported clients to plan and prepare meals. Clients shared cooking duties and mutually agreed menus in advance. There was a small kitchenette area where clients could make their own hot drinks outside set mealtimes. During the second phase of treatment, clients budgeted and prepared their meals independently. We saw a friendly atmosphere throughout the service and this was particularly evident during mealtimes.

Meeting the needs of all clients

The Bridges offered treatment to people with limited mobility issues and provided extra support if necessary. Accommodation was available on all levels and a ramp provided wheelchair access to the property for clients and visitors.

The treatment provided meant that clients needed to be able to contribute to group activities. Staff would assess this ability prior to admission. The service was able to support clients with reading or writing difficulties. Staff would verbally explain information in the first instance and offer clients the use of aids such as dictaphones to help them with their assignments and study work. The service did not have easy read materials but would tailor information to suit the needs of the client. Clients with

literacy issues were encouraged and supported to improve their skills. The service had not needed to access translators as their clients all spoke English to a level that enabled them to engage with treatment.

The 12-step approach originated from Christian beliefs. However, it refers to a power greater than that of any individual. This higher power is personal to the individual and could be any religious or spiritual power. The service did not associate itself with any religious faith or impose religion on its clients. Clients with particular religious needs still followed the 12-step approach.

Staff were aware of the diversity of their clients and had organised clients to access local places of worship. They made suitable catering arrangements for those clients with specific dietary requirements relating to religion and physical health.

Listening to and learning from concerns and complaints

The Bridges had not received any formal complaints or compliments in the 12 months leading up to our inspection. The provider had a policy in place to deal with complaints should it be needed, which laid out clear processes and detailed a timeframe for required actions. Clients we spoke with were all aware of the complaints process and we saw minutes of a meeting where they had all discussed this.

Clients could explain what they would do if they had any concerns or issues about the service they were receiving. Where clients had raised concerns, they told us that the service responded efficiently and staff kept them informed throughout the process. We saw information on how to make a complaint displayed around the building. Staff also provided clients with this information in the handbook they received on admission. We attended a daily community meeting, where staff gave clients the opportunity to raise any issues they had with the service and their peers in an open, supported and constructive way.

Are substance misuse services well-led?

Vision and values

The aim of The Bridges was to promote recovery from addiction with drug and alcohol problems and giving clients the opportunity to improve their lives. Staff told us they based their values on the ethos of the 12-step approach and the belief in recovery.

The service manager and the registered manager were actively involved in the day-to-day activities of the service and familiar to all clients. Senior managers visited the service on a regular basis and were known to staff.

Good governance

The provider had a governance policy and framework. This meant The Bridges had systems and processes that were effective in ensuring:

- staff received necessary training and remained up to date with best practice
- client activities were not cancelled due to staffing shortages
- incidents were recorded and investigated
- staff received regular supervision and a yearly appraisal
- staff followed safeguarding procedures
- complaints were recorded and investigated.

Policies were reviewed and updated when necessary and in line with new legislation and guidance. The service had a Duty of Candour policy and managers were aware of their responsibilities under this. There were very clear procedures in place for staff to follow to make sure all tasks were completed and to ensure effective communication.

The service manager attended quarterly service managers meeting and quarterly service operations meeting to monitor and improve the quality and safety of service delivery and service user care. The service had key performance targets such as treatment retention targets of 80%; they were currently achieving 90% for the year to date.

The organisational risk register and the service risk register described the operational risks in the service. Low occupancy levels and risk of client absconding were the main areas of concern. Managers told us that they felt fully supported by senior managers and they had sufficient authority to deliver the service.

Leadership, morale and staff engagement

Staff we spoke with were enthusiastic about their roles and felt supported in their work. Staff were confident about

raising concerns and they had opportunities to give feedback on the service if they wished. Staff were open and honest with the clients; there was an atmosphere in the service of mutual respect among both staff and clients. Morale appeared high.

There were no bullying or harassment allegations in the service

An organisation that worked closely with The Bridges commented that staff had recently gone through a management re-structure, which had not affected service delivery.

Commitment to quality improvement and innovation

The service used client feedback and evidence based research to consider and make continual improvements. There was an organisation wide quality improvement plan, which the provider reviewed every quarter to ensure services had improved their delivery of a particular action. For example, the quality of clients' care plans. Staff attended relevant conferences and spoke to partner organisations and referrers for feedback. The service manager spoke about their involvement in a Public Health England study about the effectiveness of rehabilitation.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The registered person must ensure stained soft furnishings are replaced immediately. They must carry out repair work to the building and refurbish the décor.
- The registered person must ensure it reports all notifiable incidents to the Care Quality Commission.

Action the provider SHOULD take to improve

- The provider should review how risk assessments include those risks affecting the client outside of treatment and update risk management plans to include any newly identified risks.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: Premises and equipment must be properly maintained and the registered person must, in relation to such equipment, maintain standards of hygiene appropriate for the purposes for which they are being used. Regulation 15 (1) (e) and 15 (2)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents How the regulation was not being met: The service had not informed the Care Quality Commission of two notifiable incidents that had occurred in the last 12 months. This was a breach of **regulation 18 (2) (e)**