Bank Parade

Quality Report

83 Bank Parade
Burnley
Lancashire
BB11 1UG
Tel: 01614840000
Website: www.acornrecovery.org.uk

Date of inspection visit: 8 May 2019
Date of publication: 28/06/2019

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated Bank Parade as good because:

- The service provided safe care. The environment was safe and clean. There were enough staff. Staff assessed and managed risk well. Staff understood how to recognise abuse and how to act on it.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. Client records were easily accessible. Staff provided therapeutic support suitable to the needs of the clients and in line with national guidance about best practice.
- The service employed ex-clients in recovery and volunteers. Managers ensured that staff received training, supervision and appraisal. The staff worked well together as a team and with those outside the service who had a role in providing aftercare.
- Staff treated clients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of clients. They actively involved clients and families and carers in care decisions. Clients were aware of their recovery plans and felt encouraged by seeing their progress develop over time.
- The service was well-led and the governance processes ensured that procedures ran smoothly.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Residential substance misuse services	Good 	See overall summary

Summary of findings

Contents

Good

Bank Parade

Services we looked at;
Residential 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 up to 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. There was a registered manager in post.

The service has been open since August 2016 and had received a comprehensive inspection in May 2017. We found no breaches of regulation during the last inspection. However, we told the provider they should improve the following:

- 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.

Our inspection team

The team that inspected the service comprised of two CQC inspectors and an assistant inspector.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited the service and looked at the quality of the environment and observed how staff were caring for clients;
- spoke with six clients who were using the service;
- spoke with two carers of clients who were using the service;
- spoke with the registered manager;
- spoke with two other staff members; including the treatment manager and the recovery caretaker;
- attended and observed one client group therapy session;
- looked at four care and treatment records of clients:
- carried out a specific check of the medication management; and

Summary of this inspection

- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke to six clients and two carers. Clients spoke highly of the emotional support they receive at Bank Parade. Clients highlighted the therapeutic programme for delivering self-reflection and a holistic approach to recovery.

Clients felt staff had positive attitudes towards them and listened to them. Clients described feeling involved in their care, including the development of recovery plans and risk management plans.

Families and carers described the service as doing a wonderful job with their loved ones. Families and carers praised staff for having kind and caring attitudes and keeping them informed about their loved one's progress. Families and carers confirmed they were given information about the service and understood the programme.

One carer felt more notice could be given in relation to client's weekend plans and visits from families.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- All areas were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough staff, who had received appropriate training to keep clients safe from avoidable harm.
- Staff assessed and managed risks to clients and themselves well and updated risk assessments regularly. Risk management plans were completed and followed by staff.
- Staff understood how to protect clients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records.
- The service used systems and processes to safely administer, record and store medicines.

Are services effective?

Good

We rated effective as good because:

- Staff assessed the physical and mental health of all clients prior to admission. They developed individual recovery plans, which they reviewed regularly through team discussion and updated as needed. Recovery plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the client group and consistent with national guidance on best practice. They ensured that clients had good access to physical healthcare and supported clients to live healthier lives.
- The service included volunteers and clients in recovery to meet the needs of clients. Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit clients. They supported each other to make sure clients had no gaps in their care. The service had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Summary of this inspection

- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005.

Are services caring?

Good

We rated caring as good because:

- Staff treated clients with compassion and kindness. They respected clients' privacy and dignity. They understood the individual needs of clients and supported clients to understand and manage their care, treatment and recovery.
- Staff involved clients in recovery planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that clients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

Are services responsive?

Good

We rated responsive as good because:

- The design, layout, and furnishings of the service supported clients' treatment, privacy and dignity. Each client had their own bedroom and could keep their personal belongings safe.
- The food was of a good quality and clients could make hot drinks and snacks at any time.
- The service met the needs of all clients who used the service, including those with a protected characteristic. Staff helped clients with advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Are services well-led?

Good

We rated well-led as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for clients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

Summary of this inspection

- Our findings from the other key questions demonstrated that governance processes operated effectively at service level and that performance and risk were managed well.
- The service had access to the information they needed to provide safe and effective care and used that information to good effect.

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 had not previously accepted referrals for people with severe and enduring mental illness, learning disability or memory problems. Therefore, the likelihood of needing to use the Mental Capacity Act had been minimal. However, the service had agreed to accept referrals for clients with complex mental health needs and therefore the likelihood of using the Mental Capacity Act in the future was increasing. The service was reviewing polices and procedures in line with this change.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Residential substance misuse services	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Residential substance misuse services

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

Are residential substance misuse services safe?

Good

Safe and clean environment

There were enough rooms to facilitate group sessions and individual counselling. The was a large group room and a small counselling room. At the time of our visit the group room was not in use due to structural repair work being needed. Clients were using the communal lounge as a temporary measure. Repair work was being organised.

Male and female single bedrooms were on separate floors of the building in order to comply with guidance on same sex accommodation. Each floor had their own bathroom facilities.

All areas were visibly clean and well maintained. A cleaner attended three days a week to clean the communal areas. Clients were responsible for cleaning their rooms daily and deep cleaning the building on a weekly basis. The caretaker checked the bedrooms regularly to ensure they were safe and clean.

Annual environmental risk assessments were completed which included ligature risk assessments. The service had drafted a new policy relating to ligature risks as there had been an increase in higher risk clients being referred and accepted into the service.

Other environmental safety audits had been completed which included building and service risk assessment, fire risk assessment, legionella checks and appliance testing.

Safe staffing

There were enough staff to meet the needs of the client group. Four staff and a volunteer were employed which included:

- service manager
- treatment manager
- housing support worker
- recovery caretaker
- Volunteer counsellor

One staff member was on long term sick leave. This absence was covered by other members of the team and where necessary staff members from other nearby Acorn services provided cover. The service had not used any agency staff or had to cancel any activities. There were no vacancies.

The service manager, treatment manager and housing support worker covered shifts from 9am to 5pm each day. The recovery caretaker was available from 5pm to 10pm and available on-call throughout the night until 9am. There was a volunteer counsellor to support the delivery of the therapeutic group sessions.

A contingency plan had been developed for cases of unforeseen staff absences. This was included with the risk register. Control measures and management plans were in place to minimise any staff risks. There was also a business continuity plan that included action to take in the event of strike action or pandemic outbreaks.

The service had a robust recruitment policy and procedure and we saw evidence that managers followed the procedure. Disclosure and barring checks had been completed before employment and every three years thereafter.

Staff completed mandatory training. The overall mandatory training compliance rate was 97%. All staff had

completed all mandatory training with the exception of safeguarding level one training. One staff member was due to complete this training on 28 May 2019. There were nine mandatory training modules which were:

- safeguarding level one
- fire safety/fire warden
- general data protection regulation
- risk assessment
- outcome star
- case note training
- medication
- first aid
- Mental Capacity Act.

Staff had completed specialist substance misuse training modules which included working with drug users safely in supported housing and adverse childhood experience training.

The volunteer staff member had also completed the induction and mandatory training modules.

Personal safety protocols and health and safety awareness training were covered by staff during the induction period. Further refresher training was available to staff but this was not mandatory. There were plans in place to review the provision of mandatory training throughout the wider parent group.

All staff had completed Mental Capacity Act training.

Assessing and managing risk to patients and staff

We examined four client records. All records contained detailed risk assessments and risk management plans. Staff developed comprehensive crisis plans for clients who were at risk of declining mental health. All risk assessments were up to date and were reviewed every six weeks or sooner if needed.

Staff were aware of warning signs and deterioration of clients physical and mental health. Staff responded appropriately to meet clients needs and minimise risks. Harm minimisation advice was provided and was an integral aspect of client care.

Staff provided examples of responding to the changing needs of clients. We saw examples of clients being referred to the mental health crisis team and jointly supported by mental health and Bank Parade staff. For one client, staffing levels had been increased to help manage risks.

Staff provided clients with information and advice regarding smoking cessation. Clients were not permitted to smoke inside the building but could smoke on the outdoor patio area.

The service had reviewed all the restrictions previously in place. All restrictions were no longer in place with the exception of mobile phones, and access to the local community. Clients handed in their mobile phones on arrival to the service. Clients could request to access them at any time and staff would return them. This policy had been reviewed with client input. Clients reported that they preferred to have this restriction to prevent relapse. Access to the local community was assessed on an individual basis. This was based on risk assessments and client's current presentation.

Safeguarding

Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies.

Staff could give examples of how to protect clients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff worked effectively with other agencies to promote safety including systems and practices in information sharing. The service had links with domestic abuse support services. Clients who had experienced domestic abuse were encouraged and supported to attend.

Staff implement statutory guidance around vulnerable adults and children. There was a safeguarding policy for staff to follow. The policy included timescales for actions and contact names and telephone numbers for local authority safeguarding teams and internal safeguarding leads. All staff were aware of where and how to refer to safeguarding. There was a safeguarding lead who staff could seek advice and guidance from. The service had two incidents in the last 12 months that involved safeguarding concerns. On both occasions the service made referrals to the local authority safeguarding teams and notified CQC.

The service was planning to implement a client safeguarding training package. The aim was to educate clients regarding safeguarding practices. It was hoped that when clients return to their home environments they will be able to recognise and report any safeguarding issues.

Staff access to essential information

Good

Residential substance misuse services

Staff were able to access essential information. Client records such as assessments, recovery plans and risk assessments were completed on paper and then uploaded onto a computer system. Paper records were destroyed immediately after being uploaded. Other records such as client daily notes were inputted directly onto the computer. Staff reported no issues accessing client records.

Medicines management

Staff had effective policies, procedures and training related to medication and medicines management. There was 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: 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. There was a medicines fridge. Clients were responsible for the re-ordering of their medication and were prompted by staff when this was necessary. The service had developed good working relationships with two local GP surgeries.

Two staff members had been recently trained in administering and training others to administer Naloxone. Naloxone is a drug used to counteract the effects of opiate overdose. There were imminent plans in place to issue Naloxone kits to clients during the unplanned discharge process.

Track record on safety

There had been no serious incidents or adverse events that were specific to this service.

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report and how to report them. Incidents and accidents were reported initially on paper and details emailed to head office. All incidents were reviewed by the data and performance manager and the health and safety performance team. There was evidence within team meetings that outcomes of incidents were feedback to staff.

Staff understood the duty of candour. Staff were open, transparent, and gave clients and families a full explanation if and when something went wrong. There was a duty of candour policy and staff knew how to refer to it.

Are residential substance misuse services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We examined four client care records. All records contained a comprehensive assessment that was up to date. Assessments contained detailed information relating to:

- finances
- alcohol and drug use
- blood borne viruses
- physical health
- mental health
- personal history
- family
- medication

Recovery plans had been developed that were personalised, holistic and recovery orientated. Information included client's views, strengths and goals. Managers were planning to review the recovery planning document, with client input, to improve quality.

Recovery plans and risk management plans were updated every four weeks or sooner if required.

Risk management plans contained detailed information relating to managing risks of individual clients. Information was clear and could be followed by staff. Discharge plans were completed prior to admission. More detailed exit plans were developed after admission. These were completed with client input and included plans for unexpected exit from the service.

Best practice in treatment and care

Good

Residential substance misuse services

Staff provided a range of care and treatment interventions suitable for the client group. The interventions were those recommended by, and were delivered in line with, guidance from the national institute for health and care excellence. This included psychological therapies, activities, training and work opportunities intended to help clients acquire independent living skills. There was a timetable of weekly activities that included:

- daily tasks
- yoga sessions
- completing diaries
- individual work
- group therapy sessions
- community activities (boxing, gym, appointments, shopping)
- meditation
- cooking lessons

The therapy provided at the service consisted of a dependency, emotional, attachment programme. 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 encouraged to plan their own activities at weekends. Weekend activities included trips to places such as the cinema or bowling.

Clients achievements were celebrated by the service. Clients who had successfully completed their recovery programme were invited to attend graduation ceremonies. Clients had the opportunity to share their recovery journey with staff, peers, family and carers.

Clients were supported to live healthier lives by various methods. Clients were registered with a local GP where a nursing examination was completed within the first week of admission and a doctors' assessment was completed within the second week. Clients were accompanied by staff to the GP surgery and attended appointments with the client's consent. Clients were given information relating to smoking cessation and how to access smoking cessation support. The service promoted healthy eating and encouraged clients to lend healthy eating cook books from the local library. Clients attended a weekly cooking on a budget lesson. Clients attended a local gym and were provided with information about local health promotion activities such as walking groups.

Recovery plans were regularly reviewed with clients. Clients had signed their recovery plans and described how they participated in completing them.

The service recognised the value of research to improve the quality of the service. There was review of the therapeutic model underway and a local university had agreed to research the effectiveness of the psychological input. The treatment manager was reviewing all national best practice and guidance to ensure the service delivered was high quality.

The service used national tier four substance misuse completion rates to measure treatment outcomes. The service implemented reviews and actions when the service noted a decline in completion rates. The service sent data to the national drug treatment monitoring service and the treatment outcome profiling system. The national 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 activity nationally.

Exit questionnaires were being used with clients who had been discharged from the service. Information was used to promote improvements within the service. Changes had been made as a result of feedback such as improving the options for weekend activities.

Skilled staff to deliver care

All staff were provided with a comprehensive induction. Staff told us they had a thorough induction with relevant mandatory training and lots informal and formal support. Induction training included:

- boundaries
- introduction to Acorn/Calico
- information governance and compliance

- safeguarding
- listening skills
- equality and diversity
- compliments and complaints
- health and safety

All staff had completed mandatory training or had been booked onto training in the near future. Staff were encouraged to use additional training provided or funded by the organisation. Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high-quality care. Staff were proactively supported to acquire new skills and share best practice. Staff had completed vocational courses such as leadership training, Diploma in Health and Social Care and a post graduate certificate in education.

Further role specific training had been undertaken by each staff member. This included training on:

- housing benefit and universal credit
- managing suicidal conversations
- working with drug users safely in supported housing
- resilience
- adverse childhood experiences

The recovery caretaker was due to complete the care certificate.

Poor staff performance was addressed promptly and effectively.

All staff including volunteers received regular supervision and yearly appraisal from appropriate professionals. Managerial supervision was delivered every six weeks. We checked the supervision records and found that over the last six months staff had been compliant with all aspects of supervision. The treatment manager received external clinical supervision. Appraisals were completed at several points throughout the year and incorporated into the supervision structure. Staff described feeling well supported.

Managers recruited volunteers and trained and supported them for the roles they undertook. A volunteer was employed to support the role of the treatment manager. The volunteer supported therapeutic group sessions and was working towards a counselling qualification. There were various opportunities for volunteers within the service including administration support and housing support roles. Clients were supported to undertake a senior peer role that involved offering informal support to other clients within the service.

The parent organisation offered nearby transitional accommodation to clients who required supported accommodation. These ex-clients frequently offered informal peer support to current clients. Ex-clients attended the aftercare group sessions and supported clients in a number of ways such as:

- escorting clients to religious services
- demonstrating successful recovery
- offering advice and guidance

Multi-disciplinary and inter-agency team work

Bank Parade offered multidisciplinary input into client care such as addressing housing needs, increasing independent living skills, improving coping strategies and promoting family relationships.

Bank Parade collated information from a range of sources which fed into client's comprehensive assessments. Comprehensive assessments contained information gathered from other sources such as community drug and alcohol teams and care managers.

Every client was appointed an individual recovery worker. Clients knew who they were, and this was clearly documented within the records.

There were handover 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 day. This included:

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

Each evening a staff member handed over to the recovery caretaker regarding any issues arising from the day.

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 were monthly team meetings.

Good

Residential substance misuse services

The service had developed a good working relationship with two local GP surgeries. Since the last inspection they had established an agreement on how they would work together.

Recovery plans included clear care pathways to other supporting services. Information included physical health, mental health, housing, drug and alcohol misuse, meaningful use of time, social networks and managing finances. Recovery plans contained detailed information on how clients could access community support in relation to these areas. The service had developed strong links with a local wellbeing organisation, mutual aid groups and the local housing sector. The parent organisation had nearby supported accommodation for clients who required extra support or were homeless.

Clients were usually discharged following the completion of the 12 week programme. Discharge plans were shared with the referrer where necessary. Clients who did not successfully complete the programme were discharged earlier. Staff followed unexpected exit from treatment plans. We saw evidence of staff working closely with community mental health teams and crisis teams to ensure clients were discharged safely.

Good practice in applying the MCA

Guidance relating to the Mental Capacity Act was contained within the safeguarding policy, which staff could refer to.

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 rarely accepted 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. There had been no mental capacity assessments completed in the last 12 months.

Clients consented to care and treatment during the assessment and admission process.

Are residential substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

We spoke to five clients and two carers. Feedback regarding staff attitudes and behaviour was very positive. Clients appreciated the honesty of staff who supported them whilst challenging their own past behaviours. Clients felt staff were visible and demonstrated compassion and understanding. Some staff had personal experience of recovering from addiction which clients felt connected with. We observed staff speaking with clients respectfully and responsively.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour towards clients without fear of the consequences. Staff confirmed any concerns would be addressed professionally.

There was a visible person-centred culture. Staff were motivated and inspired to offer care that was kind and promoted clients' recovery. Relationships between clients and staff were caring and supportive. These relationships were valued by clients and promoted by leaders. Clients described being active partners in their care and treatment.

Clients received education relating to their alcohol or substance misuse. Staff provided clients with treatment options and alternative coping strategies to manage their addiction. Staff recognised that previous trauma often resulted in addictive behaviours. Staff were aware of how to refer clients for ongoing treatment where necessary.

The service had clear confidentiality policies in place that were understood and adhered to by staff. Staff maintained the confidentiality of information about clients. The service had a record that confidentiality policies have been explained and understood by clients. This was completed as part of the assessment process.

Involvement in care

Staff communicated with clients so that they understood their care and treatment. Clients explained that they understood their recovery plans and discharge plans. Clients spoke positively about their plans and how they felt encourage by being able to visualise progress made within the plans.

Good

Residential substance misuse services

The service empowered and supported access to appropriate advocacy for people who use services their families and carers. Information about advocacy was displayed in communal areas.

Each client had a recovery plan and risk management plan in place that demonstrated the person's preferences, recovery capital and goals. Staff actively engaged people using the service and their families or carers in planning their care and treatment. Plans were developed in collaboration with clients and the clients voice was evident within the plans. Families and carers were invited to attend family conferences to help repair broken relationships with clients. This was facilitated by the treatment manager. Information was included within plans where appropriate.

There was a weekly family and carers support group provided by the service. This included a rolling 12 week programme of formal support and education regarding substance misuse as well as informal support between families.

Staff engaged with people using the service, their families and carers to develop responses that meet their needs and ensures they have information needed to make informed decisions about their care. Clients were encouraged to make informed decisions about their care. Clients were given information relating to each option and supported to make decisions. Options included:

- residential client
- day client
- 12 step programme
- dependency, emotional, attachment programme

Staff enabled families and carers to give feedback on the service they received. Families and carers could give feedback in the following ways:

- informal verbal feedback to any staff member
- suggestions box
- formal complaints process
- feedback following weekly carer group
- social media
- feedback email address

Recent feedback had highlighted that the treatment programme was intense and clients felt stressed. In response, yoga and relaxation sessions had been introduced as part of the programme.

Staff provided carers with information about how to access a carer's assessment. Staff were aware of local carers organisations where carers assessments could be accessed.

Are residential substance misuse services responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

The service had robust alternative care pathways and referral systems in place for people whose needs cannot be met by the service. This included clients with complex needs. Clients with mobility issues were offered residential care at another service run by Acorn. The alternative service had disabled access provision.

There was evidence of alternative treatment options being discussed if a person was not able to comply with specific treatment requirements. Clients who could not comply with treatment requirements had their needs individually assessed and solutions and compromises offered to clients.

Following assessments, clients were offered admission to the service once they have successfully completed their detox or are confirmed to be abstinent. Clients were offered the next available bed. Clients were assessed between two and seven day from receiving the referral. This was dependant on client's availability.

Admission criteria was based on each client's individual risk assessment. Clients with high risk needs were not accepted into the service. The service was in the process of adapting their policies and procedures so that clients with higher risks could be supported by the service.

Priority was given to clients who were deemed most vulnerable. For example, clients who were homeless would be offered a placement sooner than clients who had stable accommodation.

Good

Residential substance misuse services

Recovery and risk management plans reflected the diverse and complex needs of the person including clear care pathways to other supporting services. This included financial support, social services, housing and mental health services.

Staff planned for clients' discharge, including good liaison with care managers and co-ordinators. The service had discharged 46 clients in the last 12 months. Twenty-four were planned discharges of clients who had completed their treatment and 22 clients had unexpectedly exited the service without completing the agreed programme. The service liaised with care managers, housing departments and other organisations to ensure planned discharges were successful. The service had robust exit plans for clients who left the service unexpectedly.

Staff supported clients during referrals and transfers between services. The service had recently admitted a client whose mental health had rapidly deteriorated and required hospital admission. We saw examples of the service working closely with mental health crisis teams. The service did not discharge the client due to their homeless status. The client was supported at Bank Parade until a mental health bed was available.

The facilities promote recovery, comfort, dignity and confidentiality

Clients had their own bedrooms and were not expected to sleep in bed bays or dormitories. Clients were encouraged to personalise their bedrooms. Male and female bedrooms were on separate floors with shared bathroom facilities on each floor. 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. The group therapy lounge was not is use during the inspection visit due to repairs being required.

Patients' engagement with the wider community

Staff supported clients to maintain contact with their families and carers. Clients were encouraged to maintain relationships with families and carers. Family conferences were held where family breakdown had occurred. The treatment manager supported clients to rebuild family relationships. Families and carers were invited to write impact statements to clients. Clients discussed the impact statements during group therapy sessions. The aim was for clients to understand the impact their addiction has had on others.

Staff encouraged clients to develop and maintain relationships with people that mattered to them, both within the services and the wider community. The service endeavoured to promote supportive relationships with peers within the service and build and maintain positive relationships with people in the local area. Clients were expected to attend mutual aid groups and other community activities. The service had developed links with a local gym. Client received therapy relating to healthy relationships.

When appropriate, staff ensured that clients had access to education and work opportunities. Clients were encouraged to become volunteers within Bank Parade or the wider parent organisation. The wider parent organisation had recruited 80% of staff from within the recovery community.

Meeting the needs of all people who use the service

Staff demonstrated an understanding of the potential issues facing vulnerable groups. The wider parent group had staff champions covering issues such as:

- lesbian, gay, bi-sexual and transgender
- youth
- black and ethnic minorities

The champions were responsible for promoting specific problems faced by the groups. Other vulnerable groups such as domestic abuse victims and sex workers had access to specific support from other agencies. This included local voluntary sector organisations.

Clients using services reported that care or treatment was never cancelled or delayed. Clients confirmed that group sessions and other organised activities were never cancelled.

Listening to and learning from concerns and complaints

Staff protected clients who raised concerns or complaints from discrimination and harassment. The service had received two complaints and 15 compliments over the last 12 months. One complaint was upheld and none were referred to the ombudsman. There was a complaints policy

and we saw evidence this was being followed. Complaints records demonstrated that individual complaints have been responded to in accordance with the service's complaint policy.

The complaints system was used to improve the quality of the service. Information relating to complaints was shared within the governance structure. Information such as complaints was shared within monthly team meetings where relevant.

Are residential substance misuse services well-led?

Good

Leadership

Leaders provided clinical leadership to other members of the team. Leaders were effective and responsive to the needs of the service. Leaders had the skills, knowledge and experience to perform their roles. There was a clear definition of recovery and this was shared and understood by all staff.

Leaders had a good understanding of the services they managed. They could explain clearly how the team was working to provide high quality care. Managers knew the service well and understood the individual needs of clients. Leaders were visible in the service and approachable for clients and staff.

Vision and strategy

Staff knew and understood the vision and values of the team and organisation and what their role is in achieving that. The organisation had a vision "Through commitment, creativity and expertise, Acorn will inspire and motivate change within communities and future generations by enabling individuals to achieve a Life Worth Living". The service was due to create individual objectives for each staff member. The parent organisation had recently had a vision day. Bank Parade staff produced a short play relating to addiction, recovery and accepting support. Objectives were to be developed by staff from the vision that would feed into the organisation and parent organisations vision. Objectives would be incorporated into the supervision and appraisal system.

There was a policy and procedure in place to ensure all staff had job descriptions. Job descriptions included information such as job purpose and key duties and responsibilities.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. The service was due to review the therapeutic model which was being led by the treatment manager. Opinions of other staff were being sought. The service had voice champions who fed staff opinions into the governance structure.

Staff could explain how they were working to deliver high quality care within the budgets available. Staff were aware of budget constraints from outside of the organisation. Managers could explain how they were trying to adapt the service to deliver alterative care models. For example, clients were offered day care options as well as residential treatment. Shorter stay models were also being considered. All staff prioritised high quality care above financial restrictions.

Culture

Staff felt respected, supported and valued. During a recent staff survey staff rated their work motivation as 92%. There were staff wellbeing support groups covering a range of topics including:

- maturing well
- mental health
- move more
- general wellbeing

Staff described feeling well supported and there was high morale. There was a positive culture and staff valued being part of an effective team. The service valued employee's emotional wellbeing and had recently increased annual leave entitlement by three days to any staff member experiencing domestic abuse. Staff felt valued and part of the organisation's future direction. Staff also felt positive and proud about working for the provider and their team. Staff morale and job satisfaction was monitored via supervision, appraisals and informal discussions.

The provider recognised staff success within the service. There were individual awards that staff could be

nominated for to recognise good practice. There were annual team awards. Teams could be nominated for their good work and this would be highlighted at the staff conference.

Staff appraisals included conversations about career development and how it could be supported. Career progression and personal development were promoted by the service. Staff could access financial support to cover the costs of additional vocational training or personal wellbeing courses. This included accessing hobbies and interests such as flower arranging or professional qualifications such as degrees.

There had been no bullying and harassment cases in the last 12 months. There were policies and procedures to address bullying and harassment. There was a whistleblowing policy and staff knew how to instigate this.

Staff had access to support for their own physical and emotional health needs through an occupational health service. The human resources department had access to occupational health professionals. There was funding available for staff to attend private counselling services if needed. Staff also had access to wellbeing days that were organised by the parent organisation. This included initiatives such as:

- time away from work to complete the Yorkshire three peaks challenge
- laughter therapy
- reiki sessions
- massage sessions
- lunchtime discos
- neuro-linguistic programme sessions
- dance lessons prior to a dancing competition
- funding for marathons, half marathons and triathlons

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. The service had equality and diversity principles embedded within the corporate plan. There was an equality and diversity strategy and all staff received equality and diversity training within their induction programme.

Teams worked well together and where there were difficulties managers dealt with them appropriately.

Governance

Governance policies, procedures and protocols were regularly reviewed and improved. Polices were up to date and were in line with latest best practice and guidance.

There was a clear framework of what must be discussed at a facility, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. There was an information governance structure that allowed information to be shared from team meetings to board level. Information was reported that included quality, safety, incidents, complaints and safeguarding.

Staff had implemented recommendations from reviews of incidents, complaints and safeguarding alerts at the service level. All complaints, incident and safeguarding alerts were discussed within the senior leadership team meeting. Issues were reviewed, and any actions fed up to board level and down to service level. There had been no deaths at the service.

Staff undertook or participated in local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed. Audits completed included:

- health and safety audit
- premises audit
- medication audit
- case-note audit

Data and notifications were submitted to external bodies and internal departments as required. The service submitted data to the national drug treatment monitoring service, the treatment outcome profiling system and the CQC. Internal data was collected for purposes of quality assurance.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of clients.

Management of risk, issues and performance

There were clear quality assurance management and performance frameworks in place that were integrated across all organisational policies and procedures. There were 52 key performance indicators measuring quality and safety. Key performance indicators covered issues relating to safety compliance, financial viability, staffing, client recovery and company growth. Quality assurance reports were produced quarterly and discussed within the governance structure. There was also a governance

framework that measured aspects of quality against set standards. The service had identified actions for improvement that included the review of recovery plans and risk assessments, the review of several policies and to utilise input from staff, clients and stakeholders to drive change and improvement.

Staff maintained and had access to the risk register at service or directorate level. Staff at service level could escalate concerns when required. Staff could raise issues with the service manager and issues could be escalated to the risk register.

Staff concerns matched those on the risk register. There were 11 concerns on the risk register. Risks reflected concerns of staff and managers. Risks were mitigated and were regularly reviewed.

The service had plans for emergencies. There was a business continuity plan that included emergency measures for situations such a fire, flood or loss of information technology.

Sickness and absence rates were monitored by the service manager and the human resources team. The service manager had access to information to support the management of sickness and absence.

Cost improvements were taking place in some aspects of the service. Managers and staff prioritised client safety and ensued they did not compromise client care.

Information management

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. The service had recently moved away from paper records and now inputted all information onto the computer system. Information governance systems included confidentiality of client records. All paper records were shredded after being uploaded onto the computer system. All information needed to deliver care was stored securely and available to staff, in an accessible form, when they needed it.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Managers had access client exit questionnaires, key performance indicators, client and carer feedback, complaints and human resources to support management decisions. Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies as needed. This included the national drug treatment monitoring service, the treatment outcome profiling system and the CQC.

The service had joint working arrangements with two local GP practices. There was information sharing processes embedded into safeguarding and confidentiality policies and procedures.

Confidentiality agreements were clearly explained to clients during the assessment and admission process. This included the sharing of information and data.

Engagement

Staff, clients and carers had access to up-to-date information about the work of the provider and the services they used. This included from the internet, social media and internal meetings.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Feedback from clients was sought via a number of methods. These included:

- group work sessions
- weekly tenant meetings
- suggestion box
- client exit surveys
- complaints and compliments
- social media accounts
- email

Carers could also contribute to feedback using the complaints and compliments procedure, social media, email, suggestion box and family group feedback.

Clients and staff could meet with members of the provider's senior leadership team and governors to give feedback. There was a yearly programme in place which allowed the chief executive to visit all of the services within the company.

Directorate leaders engaged with external stakeholders. There were regular meetings with commissioners. The service met to discuss future service needs, funding issues, further extension of the day care provision, and any changes to the substance misuse landscape.

Good

Residential substance misuse services

Learning, continuous improvement and innovation

The organisation encouraged creativity and innovation to ensure up to date evidence- based practice was implemented and embedded. The treatment manager was reviewing the therapy model. The aim was to include an emphasis on adverse childhood experiences and attachment issues. The latest best practice was to be researched and a holistic model delivered. A local university had agreed to evaluate the effectiveness of the model. The service was also due to review the complaints process, seeking feedback from clients to assess and improve the complaints procedure. The service had identified that a high number of substance misuse clients have complex mental health needs. There were plans to deliver mental health training to staff over the next 12 months.

The service was a member of the Federation of Drug and Alcohol Practitioners and adhered to their standards and code of practice.

Outstanding practice and areas for improvement

Outstanding practice

The service recognised the value of continuous improvement. They were in the process of remodelling the therapeutic model. The service was researching and analysing the latest guidance and best practice relating to substance misuse recovery. There was a plan to adapt the therapeutic programme in line with this. It was hoped this would improve the chances of long term positive outcomes for clients. A local university had been commissioned to evaluate the effectiveness of the new therapeutic programme.