The Manor

Quality Report

The Manor,
Nuneaton Road,
Over Whitacre, near Coleshill,
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Website:

Date of inspection visit: 27th October 2015
Date of publication: 03/03/2016

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

- The Manor provided a safe and effective substance misuse detox and recovery service in a high-quality therapeutic environment.
- The Manor provided person-centred and individual recovery-focused treatment for all people using the service.
- Patients were very positive about the service and its success in helping them.
- Staff were very positive about their work and the support offered to them by the service.
- Senior management were in daily contact with staff and patients.
- The service had been slow to provide mandatory training to equip staff for their roles. Management were addressing this issue with an intensification of training.
- The lack of quality assurance processes in place made it harder for the service demonstrate it was providing quality care and treatment, other than through direct responses from patients.

Summary of findings

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Services we looked at:
Substance misuse services.

Summary of this inspection

Background to The Manor

- The Manor was registered in July 2013 to provide accommodation for persons who require treatment for substance misuse. It is operated by Bayberry Limited.
- The service's commercial director was applying to be registered manager at the time of our inspection. The previous registered manager had stepped down to concentrate on nursing duties.
- The Manor provides a service for male and female patients from around the UK and abroad. The majority of its clients privately fund their treatment.
- CQC had not previously inspected this location.

Our inspection team

The team comprised two CQC inspectors and was led by Martin Brown.

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 and asked a range of other organisations for additional information.

During the inspection visit, the inspection team:

- visited all parts of the service, looked at the quality of the environment and observed how staff treated, supported and interacted with patients
- spoke with eight patients
- spoke with the service's registered manager, director and chief executive
- spoke with six other staff members including clinicians, therapists and support and ancillary workers
- received feedback from local commissioners
- attended and observed a multidisciplinary review meeting
- looked at six patient care and treatment records
- carried out a specific check of medication management
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

Information about The Manor

The Manor provides its service in two separate adjacent buildings.

The Cottages provides gender-separate accommodation for up to ten people in a mix of single and double rooms. There are also kitchens, communal areas and activity rooms.

The Manor building itself offers accommodation in four separate bedroom suites. The building also contains kitchens, communal areas and activity rooms as well as offices.

The service is set in countryside with fields and woods to the rear.

Local commissioners we contacted about the service had had no contact or concerns about it.

What people who use the service say

On the day of our visit there were six patients in The Cottages and two patients in The Manor.

Patients were extremely and consistently complimentary about the service. We did not receive any negative comments from the patients we spoke with, who were either currently using the service or returning for after-care sessions.

The main themes that emerged from our interactions with patients were:

- The service's treatment was effective with long-lasting benefits.
- The environment and activities were very conducive to recovery.
- The staff were understanding, empathic, genuinely caring and prepared to 'go the extra mile' to facilitate recovery.
- The service supported patients effectively when they had specific difficulties.
- Patients remained in control of their own care while staff challenged them in caring and supportive ways.
- The service offered patients support following discharge. Staff supported patients who chose to leave prematurely and against advice to ensure they had safe destinations.
- For patients who had undergone treatments with other services, the service provided at the Manor compared very favourably, both in the experience and the results.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

- Care records we looked at showed evidence of assessments of mental capacity, evidence of consent to treatment and sharing of information, and evidence of confidentiality agreements.
- Just over 50 % of the staff had recently completed Mental Capacity Act training; the other half were registered on a forthcoming course. The service had a policy on the use of the Mental Capacity Act in its handbook for staff to refer to if needed.
- The service did not use Deprivation of Liberty Safeguards (DoLS). Patients were free to leave it if they wished. Patients past and present gave examples of where this has happened. The service ensured they were safe by giving them support.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

- The service was housed in a grade 2 listed building and therefore there were restrictions on what changes and adaptations could be made. Fire safety precautions such as smoke alarms and fire-fighting equipment were in place and regularly checked. There had been a full fire risk assessment. There were no fire wardens, but staff were aware of fire procedures. In the event of an evacuation, the service had secured agreements for suitable temporary alternative accommodation for people using the service.
- Rooms and communal areas were exceptionally well furnished and equipped, and in keeping with the environment and the listed status of the building which was over 300 hundred years old. Patients at The Manor were very positive about the cleanliness, service and quality of the environment. One patient using The Manor compared it favourably to a five star hotel.
- The environment was clean throughout. Infection control processes were in place. Cleaning and cleaning records were in evidence.
- The Cottages had a mix of shared and single rooms. Patients we spoke with were positive about sharing. One patient we spoke with said they were uncertain about sharing at first, but found it was "ultimately helpful." In the Cottages, patients were encouraged to maintain cleanliness and tidiness in their own bedrooms. Cleaning staff could offer support as required. One patient said, "It's a naturalistic environment, rather than a clinical one, which makes it far more relaxed." The rooms were gender separated, with one cottage being for men and one for women.
- Medicines were stored safely. There were procedures in place for the safe administration, storage and disposal of medicines and clinical matter. Staff were trained to administer medication. Medication records showed staff administered and recorded medicines, including controlled medications, properly. There had been an audit by an independent pharmacy earlier in the month that showed compliance with good practice. Our findings reflected this. Medication storage was in order; staff recorded temperatures daily. These were within accepted limits. The only issue raised in the pharmacy report was to ensure that BNF (British National Formulary) information was up to date. This had been actioned.

Safe staffing

- Five therapists provided a wide variety of activities throughout the day for patients. There were support workers employed throughout the day and night. Copies of staff rotas showed flexible support available, with support available in the evenings and overnight. There was at least one waking support worker on duty at night and one sleeping in staff, with a senior staff member on call. Bank staff or staff working additional hours ensured any absences did not affect the safe running of the service. Staff consistently told us there was no issue with staff shortages. Comments from all patients, past and present, we spoke with confirmed this. They all said that staff were always available at any time of day or night if needed. They said there were always staff available to support them on activities at and outside the service. They gave examples of staff supporting them to attend medical appointments.
- We raised the issue of there being only one RMN (registered mental nurse) employed by the service. We asked what the arrangements were for when this person was on holiday or absent through sickness. The director told us that other senior staff were able to fulfil the role

in line with training, but agreed to look at additional support. After our visit, the director confirmed they had engaged a nurse experienced in drug and alcohol addiction to support the existing RMN.

- The staffing matrix showed the organisation had fallen behind on training but was now ensuring staff received up to date training in key areas. The matrix showed that training for staff in many areas had recently taken place, in October. Where there were gaps, staff had already started or registered for courses. There were three areas where there was still room for improvement. These were fire safety, where formal training for staff was still less than 50%, and first aid and food hygiene, where only five of the staff had had first aid training. After the inspection, the director told us that training for these areas was being arranged and/or underway.

Assessing and managing risk to patients and staff

- Individual risk assessments were in place. These were constantly reviewed and revised in line with patients' progress. The service had clear admission criteria, they made clear that they could not accept people with severe mental or physical illness, poor mobility or active suicidal tendencies.
- We saw blank copies of the SADQ (severity of alcohol dependency questionnaires) ready to use. We did not see completed copies of these in the patient records we looked at. The service had ascertained alcohol dependencies and put in treatment plans but had not used these forms. One member of staff told us they used these as a guide but had not used them to record dependencies. They acknowledged that they could record/evidence patients' dependencies in more detail. They felt however, that the treatment provided fully met patients' needs. Comments we heard from other staff and patients echoed this. We raised the issue of lack of formal documentation of conditions with the director of the service. Following the inspection, the director informed us they had introduced CIWA (Clinical Institute of Alcohol Withdrawal Assessments) and COWS (Clinical Opiate Withdrawal Scale) forms and trained staff in their use. This enabled the service to document the ongoing condition of patients during treatment more clearly.
- A consultant psychiatrist employed by the service carried out the initial assessment and prescribed based on that assessment. The service used two consultants who were available on call if there were any queries, and would respond the same day. Both staff and patients told us consultants were readily available if they had any concerns or queries.
- In all the records we looked at, the daily care notes were clear and recorded progress, concerns and the views of the patient. For example, daily records noted how one patient had received potentially distressing news and the service made additional support available in case they needed it.

Track record on safety

- Patients all said they felt safe during their time there. They gave an example of the service acting promptly to ensure one patient's actions did not compromise gender separation. This helped minimise risk to patients. The service also gave support to patients who wished to exit the service against advice so they were able to reach a safe destination. Statements from patients confirmed this.
- We saw effective handover records that ensured any matters of concern were relayed from one shift to another.
- The service had had few incidents related to safety concerns. The most recent notification is discussed below.

Reporting incidents and learning from when things go wrong

- The service was able to reflect on and learn from incidents and events. Because of its small size, the organisation and staff were able to readily share in this learning. Staff we spoke with consistently told us debriefing and reflective sessions were held following incidents. Following comments from an outside consultant who had reviewed the service prior to our visit, management were in the process of establishing a formal, documented system to support such learning.
- The service had notified us of an incident prior to the inspection. This involved an admission that resulted in unexpected difficulties. We discussed the circumstances around this incident with staff and management. The service does not accept emergency admissions. This incident involved a re-admission at short notice of a person previously known to the service. However, the person presented behavioural difficulties and did not

wish to work co-operatively with the service. The team that had previously worked intensively with them were not present and the admission was not successful. The service had learnt from this and would no longer accept someone in such circumstances unless the staff who previously worked closely with that person was available to receive them and help them settle in.

- There was a poster in the office detailing safeguarding procedures. Staff were able to explain safeguarding procedures and confirmed they had de-briefing sessions following any distressing incident. Staff were able to identify indicators of abuse and take appropriate action. Sixty per cent of staff had completed safeguarding training. The other forty per cent were currently undertaking this training.

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

Assessment of needs and planning of care

- Staff told us everyone had a complete assessment by the consultant psychiatrist during, or soon after admission. Patients confirmed this. We saw evidence in care records of assessments by the consultant, although they had recorded these as medical notes and they were not very user- friendly. The manager agreed this assessment needed to be clearer and more accessible to all. The introduction of new assessment forms as discussed in the Safe domain in this report supported this. From discussion with staff and patients, it was clear that information gleaned from assessments was passed on to other staff and to the patient.
- We looked at four care plans during our visit and saw recovery plans in place and up to date. They were personalised, holistic, and fully orientated towards recovery. It was not recorded whether patients were given a copy of their recovery plan, but it was clear from discussion with patients that they were in regular discussion about their plans. They showed they were fully involved with them and saw and reviewed them regularly.
- Patients had a physical examination on admission and there were always doctors on call. The service registered people with the local GP service upon admission. Patients praised the effectiveness of the service in ensuring physical healthcare treatment was prompt and effective. One said, “All your health care needs are met – you don’t have to chase them.” One patient told us how the service supported them to get prompt treatment from a GP and a hospital. Another told us of prompt dental treatment. Two former patients told us their physical health was better than it had been for years since their stay at the Manor. Nevertheless, following our visit, the service negotiated with a medical practice to attend to hold a weekly surgery, commencing in November. This recognised the fact that as detox progressed, patients often became aware of underlying medical complaints. These could range in severity and vary from an earache, through to stomach pains or a whole range of other issues. The weekly surgery would provide the opportunity for patients to discuss any concerns and could alleviate anxiety about minor issues, as they would always know the day that the doctor was coming. It would allow the doctor to do a general 'check in' with the patient and feedback any concerns to the consultant and nurse.
- Staff monitored and supervised detoxification in line with treatment and risk established in the initial assessment by the consultant psychiatrist. Current and former patients we spoke with were very positive about the detoxification process. One former patient told us, “The detox was very good, everything was properly managed, and fully discussed with the consultant, myself, the nurse and staff.” Another told us, “I was seen by the doctor on admission; the detox was very well structured and I didn’t suffer any withdrawal symptoms.”

Best practice in treatment and care

- Once the detoxification process was underway, treatment and therapy began. The service tailored therapies to meet individual needs. We saw excellent practice, commitment and treatment by experienced and committed therapists, who took individual needs fully into account. The service worked in line with NICE (National Institute for Health and Care Excellence) guidelines and ensured patients were monitored and supported in order to maintain abstinence and reduce the risk of adverse outcomes. Good practice in confidentiality, dignity, and privacy helped to establish trust, and staff worked in an empathic and non-judgemental way. This was emphasised constantly

by current and former patients. The common element to people we spoke with was that staff 'really cared'. They felt that staff 'really understood' and 'did not give up on them'. One person we spoke with had been in a number of detoxification and rehabilitation services without success, but told us this was the first one where staff had properly understood and helped them. Consequently, they had since been drug and alcohol free for the longest period they had known.

- There were structured activities to meet the needs of individual patients throughout the day. There were detailed activity plans in place. Staff told us activities could be adapted according to need, but that this was always with the needs of patients in mind. Positive comments from patients we spoke with confirmed this. "The day structure is good" was a typical comment, as was "You are never left on your own. You are given space, but feel able to approach staff at four in the morning if needed." Another said, "A lot of structure is good for us." Patients said they could opt out of particular activities if there were strong reasons for doing so, such as, for example, allergies. Patients said they found the equine therapy particularly valuable, and benefitted enormously from it. This therapy took place during our visit.

Skilled staff to deliver care

- All staff we spoke with had experience in similar posts in other substance misuse or therapy services. Therapists had qualifications and training relating to their particular areas of expertise. They received clinical supervision from the clinical lead. The clinical lead had clinical supervision from a senior clinician from outside the organisation.
- All staff started on the Care Certificate within twelve weeks of having commenced employment with Bayberry. The Care Certificate is a national standard to ensure suitable induction and skills for all new staff. Those who had been with the organisation longer than twelve weeks and had already completed common induction were enrolled in the Care Certificate. This enabled them to update and build upon their own skill sets. The service had allocated a mentor to each member of staff to oversee individual progress. Bayberry had also started bi-weekly meetings between employee and mentor. This was to review completed modules and for the mentor to provide feedback. Following our visit, the director informed us that all staff had been enrolled on a substance misuse course.
- Many of the staff working with people in recovery had been on recovery programmes themselves. This enabled them to be empathic with people using the service. One patient had been on programmes at a variety of services without success before receiving funding to come to the Manor. They told us; "At Bayberry, they didn't give up on me – staff understood, having been on the same journey." This person was now receiving 'secondary', less intensive, support at the other service run by the organisation and told us they were free from addiction for the longest period they could recall.

Multi-disciplinary and inter-agency team work

- We observed a review meeting between therapists and the clinical director to discuss the progress and actions for individual clients. These meetings identified and agreed strategies and wording, ready to take these to the patient to receive their agreement or discuss amendments. Staff would note progress with particular patients in such matters as their self-awareness of their behaviours. They would see this as the first step to adjusting these behaviours. Statements on their progress and current needs were agreed and recorded, ready to present to clients at their review that day. Patients could then discuss and agree or request amendments. The meeting was detailed and ensured all aspects of the patient's addiction and the circumstances around it were examined. This was all done with the aim of helping them find robust solutions that would help them keep them on their recovery path.
- Patients self-referred or were referred through private agencies. As they came from around the UK and abroad they were often linked with support groups such as AA, which have a world- wide presence. Links had been formed with hospitals, dentists and GPs so that any ongoing physical concerns could be monitored and treated. Aftercare or secondary care was provided as necessary by the organisation. Former patients we spoke with contrasted this positively with after-care they had experienced with other agencies.

Adherence to the MHA and the MHA Code of Practice

Substance misuse services

- The service did not take people detained under the Mental Health Act. They did not accept referrals from people with a dual diagnosis of mental health problems in addition to addiction problems. We discussed an example of an older person who been referred to the service for alcohol detoxification. The service ascertained, through observation and assessment, that their problem lay with memory problems likely to be dementia related. The service discussed this with the person and their partner who had supported the referral, and they were signposted to services that were more appropriate. This showed the service was alert to presentations most likely related to mental health concerns rather than substance misuse. The care plans we looked at showed evidence of mental health assessments taking place.

Good practice in applying the Mental Capacity Act

- Care records we looked at showed evidence of assessments of mental capacity, evidence of consent to treatment and sharing of information and evidence of confidentiality agreements. This concurred with our observations and with statements by staff and users of the service, who emphasised how they were aware of and agreed with their treatment.
- Just over fifty per cent of the staff had recently completed Mental Capacity Act training; the other half had registered on a forthcoming course. The service had a policy on the use of the Mental Capacity Act in its handbook for staff to refer to if needed.
- The service did not use Deprivation of Liberty Safeguards (DoLS). Patients were free to leave it if they wished. Patients gave examples of where this has happened and how the service had supported people to ensure they were safe.

Are substance misuse services caring?

Kindness, dignity, respect and support

- We had extremely positive responses from patients concerning the care, compassion and commitment of staff. Throughout our visit we observed staff engaging with patients in a positive, caring and supportive manner. This involved all staff, from the manager to the chef. We observed calm, respectful encouragement, from staff, but also comfortable, relaxed interactions. Patients consistently told us that staff were extremely caring. They said that staff 'understood' them, as many had gone through similar experiences. One former patient told us, "I challenged, they challenged back – but with love and care."
- Staff respected patient privacy and dignity. One female patient noted approvingly that male staff were particularly careful to ensure they were not intrusive. Staff and patients were aware of the need to respect people's privacy and showed a great awareness of the need for confidentiality, particularly in groups where personal information might be shared as part of the therapeutic process. It was evident from observations and discussions that staff and patients placed great trust in each other and were equally keen not to damage that trust.

The involvement of people in the care they receive

- Patients were fully involved in their care, and treatment. One patient told us, "You write your own care plan." Patients would present plans to the therapists and to peers, and discussed and agreed with them. Where therapists devised programmes and had reviews on a patient's progress and their needs, they presented these to them for discussion and possible change.
- Sundays were designated as 'family days' when visits were facilitated. This was also an opportunity to arrange family therapy groups, according to assessed needs and wishes. Family/partner sessions took place towards the end of a programme to prepare for discharge.
- We met with family members who were visiting one person during our visit. They felt fully informed and were able to contribute. One patient told us, "The service has a very sensitive approach to family involvement. They are very good, especially with the kids."

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

Access and discharge

- People used the service for agreed treatment periods. This rarely exceeded twelve weeks. Some treatment

periods were as short as four weeks. People accessed the service via referrals from agencies, or sometimes directly. There were no waiting lists. When we visited, the service had beds available.

- Treatment was recovery focussed and discharge plans were discussed and prepared for as part of treatment. The service offered support after discharge, with provision for secondary care at another location. Alternatively, facilities and time were set aside for 'after care' sessions. These were available for people who benefitted from revisiting the service to discuss their progress post-treatment. We spoke to people taking part in these weekly 'after care' sessions and they were all very positive about the discharge process.
- There were exit plans in place in case patients chose to drop out of the service. We saw examples of these. These ensured that if patients wished to discharge themselves with little or no warning, the service would support them to ensure they had a safe destination and support from another source. One former patient we spoke with told us how they had initially 're-lapsed' and discharged themselves. They gave details of how the service had supported them and ensured they were safe. This person subsequently returned and completed their treatment programme. Another former patient told us they felt in charge of their own discharge plan. They added that although the focus was on staying, the service made sure people who chose to leave had plans in place.
- Patients also gave us the example of a patient who brought in illicit substances, which meant they had to leave. There was a proper exit plan and process in place by which the service kept them safe. A former patient told us; "They took me back after I had a relapse – I wasn't just thrown out like the other places I've been to."

The facilities promote recovery, comfort, dignity and confidentiality

- The service accepted referrals either directly from people who had learned about their service or from referral agencies. Patients came from all parts of the country and in some cases from overseas.
- Food was prepared and cooked according to individual needs and preferences of patients. The chef we spoke with told us he especially enjoyed working at The Manor because they were able to be creative and tailor each meal to individual needs and wishes within a framework of good, well-presented, nutritious food. Patients praised the quality of the food. One patient told us, "The good, healthy food helps you feel better."
- All patients we spoke with said they were happy with phone use. In most cases, phones were switched off during the day so as not to interfere with activity and therapy sessions, but a 90-minute period of access was agreed in the evenings. Any variations to protocols were discussed and agreed on an individual basis.
- There were segregated sleeping areas and separate facilities for men and women. There were some shared rooms. We discussed this with former patients who had both shared and individual rooms at different points during their stay. They said they had the choice and found that sharing a room was beneficial. They were all adamant that gender separation was clear and adhered to.
- There were plenty of rooms for group or individual activities, so there was never any difficulty in people having private space to discuss issues in private.
- The service was located in a rural area overlooking fields that were accessible. Wellingtons were available in damp weather. There were well-maintained gardens. We saw patients using these areas as places for tranquillity and reflection.
- The service supported patients to take part in activities in local towns and centres. The service provided transport and staff support for this to take place. Patients said a good variety of trips out were organised as requested and gave examples of these, to local towns, shops and cinemas.
- Patients were able to make snacks and drinks when they wished. There were restrictions on caffeine and sugars, and encouragement and support to eat healthy diets. All patients we spoke with were appreciative and supportive of this.
- Recovery plans were in place and updated to reflect individual progress and changing needs.
- There were clear pathways to progressions outside the service. These were discussed and formulated with the patient and involved families and other concerned persons.

- Each patient had a named therapist who would be his or her main source of support and advice.
- One member of staff told us the service had access to North Warwickshire Nuneaton advocacy if required, but we saw no evidence of patients using it. The service stated in its response to this question in the pre-inspection material, "Due to the demographic and the multi-faceted national and international nature of our service users we have little or no involvement with local advocacy services." Patients we spoke with were not sure if advocates were available, but were confident they would be if needed. They told us the focus was on self-advocacy and they felt the service was supportive in enabling them to do this. The current and former patients we spoke with all expressed confidence in challenging any aspects of the service. They told us "we're encouraged to challenge."
- Patients and therapists explored potential issues such as abuse as part of individual and group therapy. "Challenging, but in a very caring and supportive way" was how one patient described the approach.

Meeting the needs of all people who use the service

- The service was individually tailored to meet the needs of each patient. Dietary needs were catered for. One patient told us, "They responded immediately with the menu when they found out what foods I would not eat."
- The service was able to support diverse cultural ethnic and faith needs.
- They were not able to cater for wheelchair users, as the building, being grade 2 listed, had very limited scope for adaptations for disability access. The service made this clear in the information it provided. The least accessible parts of the building were on the second floor of the main building.
- These had low ceilings and were used as office and storage space.

Listening to and learning from concerns and complaints

- We saw details of issues raised by users of the service at weekly community meetings. These were discussed and tended to concern requests about the availability of facilities. Patients told us these were their opportunity to give feedback. They said the service dealt promptly everything they raised. Patients we spoke with all said feedback was encouraged and was used to improve the service. They gave, as an example of suggestions being listened, that in good weather they had wanted a barbecue, which had not previously been done. This was organised and enjoyed by all.
- There had been three formal recorded complaints. The service had responded to these. The most recent was over six months ago. This concerned a lapse in confidentiality regarding an electronic message being sent out which had included the names of all the recipients. One recipient had complained about this. The service had learned from this error and had put additional safeguards in place to ensure it did not recur.
- Complaints were discussed at senior board level as appropriate, with written complaints being responded to in writing. There was a clear process for responding to complaints.

Are substance misuse services well-led?

Vision and values

- The actions and ethos of the people working within the service reflected the core values of the service. Staff had embedded the values of the service, which and these informed their work. The first two core values were 'challenge everything' and 'embrace transparency'. It was clear from individual feedback by patients that these were values the service demonstrated. In setting out its visons and values, the service was able to provide practical examples of how it put these into action. These included examples of how support staff were empowered by having their suggestions acted upon, and how the service was clear from the outset about fees and admission criteria.

Good governance

- The service was still relatively small, and much of the most current feedback was via individual responses. Everything we saw and heard was extremely positive. The director of the service emphasised the difficulties they had in gathering information following the departure of patients, owing to the demographic of those coming into The Manor, a number of whom came from other countries. The majority of these patients were, he said, reluctant to engage in any mid to long-term feedback and, as such, accumulation of detailed information was difficult. We saw

approximately twenty 'thank you' cards, all praising the nature and effectiveness of the treatment given by the service. Individual responses from people we met who were subsequently using the 'after care' service were extremely positive.

- The service had done a survey and analysis in 2014 of health care professionals treated at Bayberry. This showed good outcomes from treatment and aftercare, with figures showing an overall 90% success rate. At present, the Manor did not have quality assurance measures to ascertain the effectiveness of its work. The director informed us plans to prepare a similar study for the Cottages were underway and that the service estimated that it would undertake this by February 2016.
- The service had a system in place for monitoring and managing risk. The director explained the IT system they used by which issues raised were assigned to a named person for resolution and remained on the system until they were resolved.
- Emergency plans were in place. Arrangements were in place for alternative accommodation in case the service ever needed to evacuate the premises.

Leadership, morale and staff engagement

- The management structure had clinical leadership in place, with a clinical director and senior clinical manager as part of the senior management. Staff were able to get clinical support and supervision as well as management supervision. This took place on a monthly basis.
- The commercial and administrative team was separate from the clinical team. This helped the service to keep its clinical aims distinct from the commercial and business aims. This enabled the service to remain commercially viable while meeting people's clinical needs. The clarity in relation to fees and admission criteria demonstrated this. The director explained that initially the service had treated people without being clear agreement on the payment of fees and there had been conflicts between meeting people's clinical needs and recovering costs. He said that now costs were settled prior to treatment, so that commercial factors did not conflict with clinical issues.
- Each of the senior team had outlined roles, so it was clear who had responsibility for particular areas such as, for example, admissions, and clinical training.
- Staff consistently told us the manager was approachable and that staff could get support at any time from their colleagues or immediate management.
- Staff felt valued and able to raise issues and be listened to when they suggested improvements. The chef, for example, was able to suggest and have changes made in procuring supplies.
- The service did not monitor absences in a formal way. The director said that as a small service, they would be aware of any sickness concerns. They said that sickness rates were low. Discussions with staff and current and former patients confirmed this.
- Staff were very positive about their work. They did not feel under pressure by having excessive caseloads or by being rushed or pressurised. Staff told us that the nature of the work was stressful as it was so intensive, because they explored reasons and therapies for addictions so deeply and personally. One staff told us there was "an appropriate level of stress." Staff consistently told us there were suitable support mechanisms in place. Therapists told us that the nature of the work at The Manor was more intensive but more satisfying than work they had previously done.
- Patients were able to make suggestions and have discussions at the regular weekly community meetings about improving services. A recent example of this was having a barbecue to celebrate the Rugby World Cup. Staff and patients saw this as a particularly successful gathering as it showed all that such an event could be enjoyed by all without alcohol.

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Commitment to quality improvement and innovation

- The service saw the introduction of a 'luxury boutique style' treatment centre at The Manor as an innovation, offering a service to people from all over the country and internationally, with a 'bespoke' approach to each person using the service**.**
- The service had applied for accreditation with Investors in People. It was in the initial stages of preparing for this.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure it has sufficient formal quality monitoring measures in place to enable it to be fully aware of trends in performance, staff absence and morale.