Phoenix Futures National Specialist Family Service

Quality Report

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

Ratings

Overall rating for this location	**Good**
Are services safe?	**Requires improvement**
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.

Summary of findings

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

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

Overall summary

We rated Phoenix Futures National Specialist Family Service as good because:

- The service completed appropriate health and safety assessments of the environment including risks associated with mixed sex accommodation. The service had good facilities including the nursery, lounge and garden facilities with play equipment.
- Staff directed clients to other services when appropriate and supported them to access those services. Staff supported clients to lead healthier lives. Clients had planned discharge exit packs which included harm reduction advice and details of their resettlement plans.
- Safeguarding was fully embedded in the service. The service worked collaboratively with other agencies and referred, shared or escalated concerns as appropriate.
- The service had improved and resolved issues relating to medicines management practices following our last inspection. Staff turnover and sickness rates were improving following recruitment to vacant posts.
- The nursery within the service provided care for clients' children in an outstanding rated OFSTED environment. This allowed parents to access the therapeutic program and have guidance on childcare and development from qualified childcare workers.
- Clients were offered practical and emotional support by staff and others in the therapeutic community. Group meetings and therapy were delivered in a relaxed, friendly atmosphere.
- Clients were fully engaged and participating in their care and treatment. Personal information, histories and recovery goals were evident in care plans and group discussions. Staff supported clients to maintain contact with their families and carers.
- Families and carers spoke positively of the staff and care and treatment provided; they were happy with the outcomes of the treatment. The service sought client input and made changes following discussions.
- Staff felt proud to work for the organisation. They felt valued and respected and could raise concerns without fear of retribution. Staff told us they felt connected to the company.
- The service followed an effective and clear framework to share information. Team meetings, supervisions and handovers had a set agenda that ensured that staff were kept informed of essential information such as client risk and care and learning from incidents or complaints.
- The organisation encouraged creativity and innovation to ensure up to date evidence-based practice was implemented and embedded. They had achieved recognition for their work from multiple external sources.

However:

- The service did not have total oversight of the training completed. Sessional staff had not completed all the required training and night staff training compliance figures were not provided.
- Staffing shortages and vacancies meant that clients' one to one sessions did not always occur weekly as detailed in the provider's local protocol and that client leave was not always accommodated.
- The organisation did not provide clarity around the night staffing expectations.
- Support plans and client files did not always reflect the levels of personal knowledge and support given by staff.
- Actions on the continuous improvement plan had been marked as complete when they were not yet fully resolved.
- The service did not have an overarching improvement plan that included the work the service was doing in response to client feedback. The service did not have any formal mechanisms to obtain feedback from carers about the service.

Summary of findings

- Governance policies, procedures and protocols did not include an equality impact assessment and the service did not have its own service level risk register.

Summary of findings

Contents

Good

Phoenix Futures National Specialist Family Service

Services we looked at
Substance misuse services;

Summary of this inspection

Background to Phoenix Futures National Specialist Family Service

Phoenix Futures National Specialist Family Service offers residential treatment for parents experiencing drug and/or alcohol problems whilst remaining the primary carers for their children. The service can accommodate 12 families including single parents, pregnant women or couples looking after children up to the age of ten. Children can live with their parents in the service. Children can attend the onsite nursery, currently rated Outstanding by Office for Standards in Education (OFSTED), or enrol in external childcare provision or school to allow parents to participate in treatment. Each family has their own room and access to a shared kitchen and bathroom facilities.

The service offers two flexible treatment programs of either 12 or 26 weeks. Programs consist of three elements:

- therapy, to help clients address their substance misuse.
- parenting, where support is offered by specialist childcare workers to improve clients' parenting skills.
- childcare, that includes the on-site nursery and crèche.

The service also offers an on-site medically monitored withdrawal program for clients that are physically dependent on substances, including alcohol. The service accepts referrals from community services across the country including substance misuse teams, social care organisations, courts, and privately funded clients.

The National Specialist Family Service has been registered with The Care Quality Commission since 20 January 2011 to provide accommodation for persons who require treatment for substance misuse and has a registered manager and a nominated individual in post.

The Care Quality Commission has previously inspected Phoenix Futures National Specialist Family Service on four occasions. At the last focussed inspection in July 2017 we issued the provider with one requirement notice under Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17: Good Governance.

Following that inspection, the service sent us a plan, which set out the steps they would take to meet the legal requirements of the regulations.

We did not rate the provider on previous occasions in line with the methodology at that time.

Our inspection team

The team that inspected the service comprised of a lead CQC inspector, two CQC inspectors, one CQC assistant inspector and one specialist adviser with experience of working in substance misuse services.

Why we carried out this inspection

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

Summary of this inspection

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- looked at the quality of the environment and observed how staff were caring for clients;
- received feedback about the service from one commissioner;
- spoke with four clients and held a focus group for five other clients who were using the service;
- spoke with two carers whose families were using the service;
- spoke with the registered manager for the service;
- spoke with eight other staff members including a doctor, childcare manager, program manager, therapeutic worker, care team worker, administrative staff, student social worker and director of operations;
- spoke with the pharmacist contracted to provide pharmacy services;
- attended and observed one hand-over meeting;
- attended two client groups;
- looked at eight care and treatment records of clients;
- carried out a specific check of the medication management including a review of 18 clients and children's prescription charts; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

During the inspection we spoke with four clients individually and held a focus group for a further five clients. We also spoke with two carers following the inspection. People that used the service emphasised the quality of the treatment program. They said that the service helped them to establish a routine and helped them to identify clear responsibilities that allowed them to care for their children while recovering from their addictions.

Families and carers said that the service had transformed their loved ones. Clients appreciated the support of the members of the therapeutic community and staff. They said they always felt safe in the environment.

Some clients did however share some concerns about the service. They were frustrated when staff did not consistently apply the 'house rules' to all clients and felt that activities could be more appropriately targeted to the age range of the children. Clients said that although they were not always clear about the expectations of the program prior to admission, the service helped them to settle into the service when they arrived. Some clients felt that staff could be judgemental.

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?

Requires improvement 

We rated safe as requires improvement because:

- There was a lack of clarity regarding the provider's training compliance target; the manager said the rate was 75%, however following the inspection, the head of quality said that there was no set target.
- Although all sessional staff had started to complete mandatory training, all courses were not fully completed. 67% of sessional staff had completed paediatric first aid training and 20% had completed the care certificate. These figures were below the average training target of other similar services.
- Managing challenging behaviour training was not mandatory but was required for lone working and compliance figures did not meet the provider target. 59% of sessional staff and 50% of therapeutic staff had completed this training.
- The service did not always provide a waking night member of staff even when staff sickness or shortage was expected.
- Staffing shortages caused by vacancies and illness impacted on the availability of staff escorts and one to one key working sessions.
- Children and adult's risk management plans were not always updated following an incident.
- Crisis planning documentation was limited and did not fully support staff to calm clients in a crisis.
- The service did not use a structured program to continually review if all restrictions were necessary.

However:

- The service had completed appropriate health and safety assessments of the environment including risks associated with mixed sex accommodation.
- Staff turnover rates were improving following recruitment to vacant posts.
- Client's mental health needs were identified and acted on. Staff responded to sudden deterioration in clients' health by engaging appropriate services.
- Safeguarding was fully embedded in the service.
- The service worked collaboratively with other agencies and referred, shared or escalated concerns as appropriate.
- The service had improved and resolved issues relating to medicines management practices following our last inspection.

Summary of this inspection

- Learning and actions to respond to risks and incidents were shared at team meetings. Staff could describe investigation outcomes.

Are services effective?

Good

We rated effective as good because:

- The staff team attended thorough and complete handovers where up to date information was shared.
- Staff managed clients leaving the service in an unplanned way well. They completed an early leavers pack which included written advice on safe coping skills, contact numbers and emphasised the effects of drug use on themselves and others.
- Staff used a recognised assessment tool prior to and on admission to help clients identify goals that were incorporated into their care plan
- The service provided care and treatment interventions suitable for the client group based on recognised best practice guidance.
- The nursery within the service provided care for clients' children in an outstanding rated OFSTED environment. This allowed parents to access the therapeutic program and have guidance on childcare and development from qualified childcare workers.
- Staff supported clients to lead healthier lives.
- The service benchmarked its success against other services and monitored and compared treatment outcomes
- The service provided all staff, including sessional staff and students, with a comprehensive induction.

However:

- One to one sessions did not always occur weekly as detailed in the provider's local protocol. Clients found this disruptive to their care.

Are services caring?

Good

We rated caring as good because:

- We observed most staff to be caring, compassionate and respectful.
- Clients were offered practical and emotional support by staff and others in the therapeutic community. Group meetings and therapy were delivered in a relaxed, friendly atmosphere.
- Staff directed clients to other services when appropriate and supported them to access those services for example, mental health services or maternity care.

Summary of this inspection

- Clients received a clear induction to the environment and the expectations of the service on admission.
- Clients were fully engaged and participating in their care and treatment. Personal information, histories and recovery goals were evident in care plans and group discussions.
- The service sought client input and made changes following discussions
- Families and carers spoke positively of the staff and care and treatment provided; they were happy with the outcomes of the treatment.

However:

- Support plans and client files did not always document the levels of personal knowledge, care and support given by staff.
- Some clients said that keyworker sessions and escorted leave were not always accommodated. They also described an inconsistency in house rules being applied.
- The service did not have any formal mechanisms to obtain feedback from carers about the service.

Are services responsive?

Good

We rated caring as good because:

- The service had clear admission criteria and a dedicated member of staff to complete all preadmission checks.
- Client folders included support plans and risk management plans that reflected the complex needs of the clients.
- Clients had planned discharge exit packs which included harm reduction advice and details of their resettlement plans.
- The service had good facilities including the nursery, lounge and garden facilities with play equipment.
- Staff supported clients to maintain contact with their families and carers.
- All clients and families knew how to complain and felt comfortable doing so. Clients told us that complaints were acknowledged and responded to.

However:

- We observed that clients were not allowed any food or drink in their bedrooms.
- The choice of activities could have been improved and more targeted to the children's age ranges.

Are services well-led?

Good

We rated well-led as good because:

Summary of this inspection

- Leaders had a good understanding of the services they managed. Managers had the skills, knowledge and experience to perform their roles.
- Staff felt proud to work for the organisation. They felt valued and respected and could raise concerns without fear of retribution. Staff told us they felt connected to the company.
- The service recognised staff achievements via awards ceremonies and service wide emails.
- The service followed an effective and clear framework to share information. Team meetings, supervisions and handovers had a set agenda that ensured that staff were kept informed of essential information such as client risk and learning from incidents or complaints.
- There was a clear quality assurance management and performance framework in place that was integrated across all organisational policies and procedures. The service had clear policies and local protocols.
- The service used an accessible electronic information management system that allowed managers to collect data and analyse performance.
- The organisation encouraged creativity and innovation to ensure up to date evidence-based practice was implemented and embedded. They had achieved recognition for their work from multiple external sources.

However:

- Actions on the continuous improvement plan had been marked as complete when they were not yet fully resolved. The service did not have an overarching improvement plan that included the work the service was doing in response to client feedback.
- Governance policies, procedures and protocols did not include an equality impact assessment and the service did not have its own service level risk register.
- The organisation could not provide clarity around the night staffing expectations.
- Sessional staff had not completed all the required training and night staff compliance figures were not included in the compliance data submitted by the service. The manager did not have total oversight of the training completed by staff.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Capacity was assessed as part of the referral process and staff assured us that if there were any issues with capacity then these would be addressed with the client's care coordinator before admission. If a client was incapacitated during their assessment, then staff would rearrange the appointment.

The service provided training and had a policy on the Mental Capacity Act, which staff were aware of and could refer to if needed. 88% of staff had completed the training and additional intensive training was also available to staff as part of their personal development. Phoenix Futures also had a clinical lead who they could approach for advice.

Deprivation of Liberty Safeguards was not applicable to clients using this service.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Substance misuse services	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Notes

Good

Substance misuse services

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

Are substance misuse services safe?

Requires improvement

Safe and clean environment

Safety of the facility layout

Phoenix Futures National Specialist Family Services is a residential service located within an old building. Facilities were not suitable for wheelchair users. Families had their own bedrooms on the upper floors of the building and they shared kitchen and bathroom facilities with other families. Staff completed environmental safety checks every 30 minutes during the day and completed risk assessments prior to admission. The service reviewed sexual safety and if there were any potential risks to clients or children, the client would not be admitted to the service. Risk assessments also included environmental risks and risks relating to mixed sex accommodation and ligature points. A ligature point is something that a person could tie something to in order to strangle themselves. Staff risk assessed clients, their histories and any potential risks to children. The service completed appropriate fire and health and safety checks.

Maintenance, cleanliness and infection control

The environment was clean and tidy. Clients completed daily cleaning duties as part of their recovery program. This helped clients to establish a daily routine. In addition, staff completed daily checks. Staff adhered to infection control principles, including handwashing and the disposal of clinical waste. Infection control and control of substances hazardous to health posters were displayed on the premises.

Clients told us about problems with the maintenance of equipment such as the buzzer to get into the building being broken and lights or cookers not fully working. They said there was sometimes a delay in items being fixed. The Phoenix Futures quality team had completed a quality check of the service in July 2018 and had identified maintenance as an area for improvement. Clients and staff now completed a maintenance request form and the maintenance worker signed the form once completed. We requested the maintenance work log following the inspection which said that since June 2018 the service had completed repairs on seven work requests. Although the work requests showed a timely response, we did not find the log reflective of the actual upkeep of the property.

Safe staffing

Staffing levels and mix

The service employed 17 members of staff. This included managers, administrative support staff, therapeutic workers, care workers, waking night staff and childcare workers. The service also employed sessional workers who covered any shortfalls in the staffing provision, for example to cover sickness or annual leave. Sessional staff received an induction and were expected to complete mandatory training. The service also employed a nurse on a part time basis. This post had been vacant but had recently been recruited to and a start date agreed.

Staff worked a combination of early, late and day shifts, and one member worked waking nights. Childcare workers worked day shifts, Monday to Fridays. When there was a new admission, childcare workers stayed late to ensure that parents had the skills, and the support, to care for their child.

The manager planned rotas and staff diaries seven to ten days ahead to ensure there was an appropriate skill mix

and sufficient staffing on each shift. However, we saw gaps in staff provision when we compared planned and actual rotas. Staffing shortages were heightened because two members of staff were off with long term health conditions. During the day, the service used sessional staff, management staff and childcare workers from the nursery as cover. The caseload of staff was distributed among the other care staff. The service had an upper caseload limit and this had not been reached with the additional cover being provided by other team members.

Between 1 August 2017 and 6 September 2018, 185 shifts had been covered by sessional staff; Of these,113 were to cover vacant night staff posts or night staff sickness. The service reported that all shifts had been covered however we did not see this to be the case when we viewed the actual rotas, particularly for the night shifts. Between 8 October 2018 and 14 November 2018, we saw 18 occasions where the service had no waking staff on night shifts between midnight and 7.00am and two occasions where there was no waking staff after 10pm. This meant that 54% of night shifts in this five-week period did not have waking staff on shift.

The provider said that when a staff member was sick for night shift they covered the shift with another waking night worker, agency worker or the allocated standby staff member or on-call manager as required. We further queried the night staffing arrangements identifying specific gaps in the rota and the manager confirmed they used sessional workers to do a sleep-in shift. i.e. staff go to sleep at midnight and can be alerted by a client if support is required between midnight and 7am. We also reviewed the rotas between 29 January 2018 and 7 October 2018 to confirm if this was the standard service provision and identified that staff had slept nights 37% of the available shifts in this period. We saw that the sleeping night shift was used to cover vacant posts or long-term sickness. However, the provider communicated these arrangements to clients, so they were fully aware of which staff member was on shift and how to alert them if required. Clients confirmed this.

The service determined that where possible waking nights cover would be provided. However, if due to sickness or other absence this was not possible through the pool of waking night staff, the option to cover using the wider team resource should be considered. Alternatively, sleep in cover using existing permanent or sessional staff should be considered. Some clients felt that night staffing was not always sufficient. For example, when children were unwell there was not enough staff on shift to support them which could cause delays in accessing treatment. We found the night staffing arrangements unclear. All staff, including senior managers told us that they provided a waking nights service until we queried the gaps in the rotas. We also saw that the service did not provide waking staff on a regular basis.

The service had considered when staff were lone working and had a policy and e-learning in place to support staff. The service had a lone working pack which contained a handheld phone to call for assistance from either staff or police. We saw when there was an increased risk to staff and clients' safety, night staffing had been increased. The night staff member also had access to an on-call manager who could attend the premises quickly if needed; they could also access their on-call senior manager if needed. Staff told us that managers were available, and they felt safe. However we were not assured that the provider was complying with local working protocols identified in the lone working risk assessment. This stated that staff should have completed training in managing challenging behaviour. The overall training compliance figure was 61% for this course; 59% of sessional staff, and 50% of therapeutic staff had completed the training.

Clients said that there were not always enough staff on shift to meet all their needs. They described one to one's with key workers and escorted trips being cancelled or rearranged. Clients in the early stages of admission must be escorted when leaving the service. We reviewed eight client care files and saw that key working sessions were cancelled or not always occurring as regularly as specified in the service's policy in four of the records. Staff said that they had to sometimes be flexible with one to one times, and that leave could be cancelled if there was a medical emergency or an incident in the house. We saw one session that was cancelled due to annual leave and another was cancelled by management with no reason given.

Between 1 August 2017 to 31 July 2018 the service had nine staff leavers, 53% staff vacancies and 5.9% sickness. During the inspection, we were advised that vacant nurse and night worker posts had been recruited to and staff were due to start by the end of the year. The manager explained that 61% of staff had worked in the service for over one year and the high vacancy and turnover rate related to

night staff and therapeutic workers. Following the inspection, the service provided figures that showed that turnover had improved since filling the vacant posts. There was one vacant post which equated to 5.8% between November 2018 and 2018.

Mandatory training

During the inspection we requested confirmation that all staff had completed their mandatory training as these figures were not provided during the pre-inspection intelligence gathering stage. The manager explained that in response to a requirement notice issued at the previous CQC inspection, the service had introduced a training matrix that identified what staff roles required what specific mandatory training. Training certificates were stored in the individual's personnel file. We requested to see training compliance figures during the inspection however these were not available as this oversight was lost at manager level following the introduction of the updated training matrix. However, the manager was confident that staff training was in order because this was discussed at supervision and regular team meetings. There was a lack of clarity regarding the provider's training compliance target; the manager said the rate was 75%, however following the inspection, the head of quality said that there was no set target.

Following the inspection, the provider supplied evidence of mandatory training compliance. Night staff training compliance rates were not included in the training figures submitted. Average training compliance for all courses, across all the other staff groups was 95%. Training included mandatory health and safety awareness and the Mental Capacity Act 2005. Mental health awareness training was included in the care certificate. Additional, more detailed, training in the Mental Capacity Act 2005 and Mental Health Act 1983 was also available to staff as personal development.

However sessional staff had not completed all of their mandatory training. 67% had completed paediatric first aid training and 20% had completed the care certificate. This meant that staff covering shifts for sickness and vacant posts may not be fully qualified in accordance with the service's identified mandatory training. The service acknowledged that due to shift patterns it was challenging to complete all of the care certificate modules, however all sessional staff had started the training. The service said that staff that had not completed paediatric first aid training were scheduled on shifts with staff that had completed this training.

The lone working risk assessment identified that staff should be trained in managing challenging behaviour, however training compliance figures did not meet this requirement. We reviewed the additional training matrix and overall training compliance was 61% for this course. 59% of sessional staff had completed this training and 50% of therapeutic staff had completed the training.

The service had policies in place for the Mental Capacity Act 2005 and Mental Health Act 1983 and we saw that client's mental health needs were identified and acted on. We saw that multiple clients had needs relating to self-harm, attention deficit hyperactivity disorder and suicidal ideations. These were identified and resulted in contact with the local mental health services for an assessment. However, one client's file had a medical assessment that queried if the client had previously been sectioned under the Mental Health Act, but this was not reflected or addressed in their risk assessment.

Assessing and managing risk to clients and staff

Assessment of client risk

Staff started assessing risk when they received the initial referral. This was because certain risks would exclude clients from being admitted such as a recent history of violence or any history of sexual abuse. Staff would then complete a comprehensive assessment with the client. This fed into the client's risk assessment and management plan on admission. Staff attempted to complete assessments face to face, however because clients could be admitted from hospital, or have no fixed abode, these were also conducted by phone. Staff also completed a risk assessment for any child entering the service with their parent.

We reviewed eight client folders. Seven clients had a risk assessment and management plan in place however they varied in quality. Risks were assessed in relation to mental health, substance misuse, forensic history, housing, neglect, family and children, sexual practices, physical health and treatment issues. Management plans followed a standardised approach for known risks such as substance misuse, but we also saw some additional personalised details recorded. In one record, following a significant incident, the increased risk had not fed back into the risk

management plan. However, this information was visible in handover notes and keyworker notes. We also saw generic wording throughout pregnancy risk assessments. Instead of using the clients' names, they referred to 'mum' throughout the documents.

Children's risk assessments were stored in the parent's folder. These were also generic and parental risks were not always updated in the child's risk assessment, for example, when parent's mental health deteriorated. Although parts of the risk assessments were generic, they were reviewed in line with the timeframes identified in the policy or following an incident. However, we did not always see risk management plans being updated and felt that content could be more individualised. The Phoenix Futures quality team had completed a quality check of the service in July 2018 and had identified risk assessments as an area for improvement.

Crisis planning documentation in the service was limited. Staff completed a one-page document with clients that identified signs and triggers relating to crisis. There were few identified actions to help calm clients or direct staff how to help the client in crisis. For example, actions identified were reminding clients why they were in the service and emphasising the possibility of losing parental rights for their child. One crisis plan didn't reflect the client's mental health needs that were identified in their care plan. Client files contained contact information for local crisis services, the Samaritans and social worker's contact details. However, in practice, staff recognised and responded to warning signs and deterioration in client's health. They discussed concerns at handovers and ensured clients were safe. The service also had an unexpected leavers pack that they completed before any client left.

Management of client risk

We spoke with four clients and held a focus group with another five clients. Although clients were unclear about what a risk assessment document was, they understood the risks and consequences of continued substance misuse. Harm minimisation and safety planning was evident in the clients' care plans and in the therapeutic approach used by the service.

The service did not fully follow best practice in implementing a smoke-free policy as clients were able to smoke in designated outside areas in the garden. However the service told us that not allowing clients to smoke in safe, designated areas onsite would put them at greater risk. For example if they were to leave the grounds to smoke.

Staff checked clients' wellbeing regularly during environmental checks and group sessions and identified and responded to changing risks to, or by, clients well. Information was shared and recorded at handovers and in the house checks log.

Staff responded to sudden deterioration in people's mental and physical health by engaging with mental health services, accident and emergency services, 111, or the police; general physical health issues were primarily managed via the client's GP. Clients registered with a local GP on admission and were referred to specialists when needed. A health visitor attended once a week and pregnant clients attended antenatal, midwifery and clinic appointments. One care plan identified a physical health need for a client that had not been transferred back into their current risk assessment.

Use of restrictive interventions

The service had set rules that clients had to abide by. While many of these complemented the recovery program, clients told us that rules were not always enforced by staff consistently. We saw a member of staff query with a senior manager if they should give a sanction to a parent that had bought in a sandwich from a takeaway shop because takeaways were only permitted at weekends. Clients provided other examples relating to clothing requirements when accessing medication and sanctions for behaviour.

Clients handed in their mobile phones on admission and were able to contact friends and family between 4pm and 11pm for a 20-minute allocated slot using a payphone. Although clients understood the rationale for this restriction, (safeguarding children and use of camera phones, minimising disruption during the daily therapeutic program and client access to undesirable influences,) one client said that they spent £5 a day on calls to friends and family. This placed an unnecessary and additional strain on clients' finances.

Clients used the staff office phone to call additional children and professionals and staff risk assessed client use of mobile phones for home visits, hospital visits and any unescorted meeting attendance, for example court attendance. They said if a client had insufficient funds to

use the pay phone to speak with friends and family then they would allow them to use the office phone, however we did not see this information being openly shared with clients.

Additionally, clients did not always understand what the rules were prior to admission. Clients could be admitted via the courts, from maternity units and others had no fixed abode so written information regarding restrictions was not always available. Staff explained restrictions over the phone. The registered manager acknowledged that a client satisfaction survey had highlighted a lack of preadmission information being shared and that they were reviewing how to improve this. Following consultation with clients, the service had started to send both email copies and physical copies to potential clients, their families and the referring agencies.

The service did not use a structured program to review restrictions within the service. The management team said clients were informed of the community structure and restrictions prior to and following admission, and that clients were able to question the rules via groups, complaints, suggestion boxes etc. However, we found that clients were not fully aware of the service model in advance. The service said that restrictions were kept to minimum, collaboratively agreed with service users, and had the appropriate flexibility to adapt to individual circumstances. We saw that changes were made to the allocated television times in response to client feedback. However, we had concerns that clients might not want to challenge the rules once admitted for fear of losing legal parental care of their children. Clients did not raise this as an issue.

Safeguarding

Safeguarding was embedded in the service. Staff received mandatory safeguarding training and understood their responsibilities for safeguarding children and adults in the service. They described different types of harm and abuse and provided examples of steps taken to safeguard clients and their families.

Safeguarding training levels were dependent on job role; 100% of staff had completed level one and three safeguarding training and 85% of staff had completed level 2. Safeguarding level two training was booked for other 15% of staff. The service had a safeguarding lead, a clear policy for safeguarding both children and adults and safeguarding was a standing agenda item at team meetings. The service worked collaboratively with other agencies and referred to, or shared concerns to referrers, local authorities, schools, nurseries, social workers and police as appropriate. For example, staff attended looked after children reviews and multi-agency meetings. They contacted out of hours social workers when incidents occurred at night and had positive working relationships with the police.

Staff could give examples of how to protect clients from harassment and discrimination, including those with protected characteristics under the Equality Act. The service admitted same sex parents and pregnant clients and staff said they would be able to accommodate transgender clients.

Staff access to essential information

The service used paper records that were not always up to date. Each client had a folder with referral information, risk assessments and management plans, support plans based on recognised outcomes tools, medicines reviews and progress notes.

Staff also attended handovers or reviewed the handover log and daily log book for current information. The handover folder held the last two weeks' worth of key information from handover meetings. This was later incorporated into the clients' files. The daily log book was a book used to share information within the team, for example the day's plans or house checks.

Although information was stored in multiple places, we had no concerns relating to staff's knowledge of clients. Staff explained that the most current client information was available through the log books and notes. We were not confident however, that all information shared at handovers was fed back into the client's care plans or risk management plans in a timely way.

The service planned to move to an electronic records management system in March 2019 and staff thought that this would help with records keeping.

Medicines management

At our last inspection we issued a requirement notice for medicines management practice. Issues related to medicines fridge temperature monitoring and recording, self-administration risk assessments not being reviewed, and detoxification protocols were not finalised. These had been resolved by this inspection. Medicines fridge temperature checks and recording were in place and a

standing agenda item at team meetings and clients that self-administered were risk assessed and regularly reviewed. We reviewed two detoxification files and saw that staff followed the now finalised detoxification protocols and policies.

The service had effective policies, procedures and training related to medication and medicines management including prescribing, detoxification, assessing people's tolerance to medication, and take-home medication. The service contracted a speciality detoxification doctor who was medically responsible for clients' detoxification. They attended on admission to assess clients, prescribed appropriate medication for their detoxification regime, and met with clients every week. Trained staff completed the physical health checks as indicated by the detoxification doctor in line with best practice guidance.

The clinic room was small. The service had identified this as an issue and were in the process of moving the clinic room to a larger space to better facilitate medicines management. Storage of controlled drugs was safe, and the register included a photograph of clients to further ensure the safety of medicines taken.

Staff followed good practice in medicines management including storage, dispensing, administration, medicines reconciliation and recording and did it in line with national guidance.

A local pharmacy completed annual medicines audits in addition to weekly local audits completed by the provider. The medicines policy indicated that pharmacy audits were to be completed every six months, however these were being completed annually which was not in accordance with the organisational policy. Medicines incidents were being reported and audits were effective. For example, when a client's medicine was not administered the service had identified that the reason code was not always completed of the client's chart. The service had discussed this with staff at team meetings and had seen improvements.

All staff described good working relationships with the local pharmacies and detoxification doctor.

Track record on safety

The service reported five serious incidents between August 2017 to July 2018. Two of these met the service's serious incidents criteria. The others were triaged and then investigated via disciplinary, safeguarding or complaints procedures.

We reviewed the serious incident reports and investigations and saw that staff reported incidents internally as well as informing appropriate external organisations. Where incidents related to clients' behaviour, the service ended their placement. Where incidents involved children, the service completed thorough investigations and involved parents and multiple external agencies including schools and social workers. We saw that learning and actions to respond to risks were shared at team meetings and staff could describe investigation outcomes.

Reporting incidents and learning from when things go wrong

The service had recently introduced an electronic incident reporting system. Between 15 July and 13 November 2018, the service recorded 19 incidents that included incidents of illness, medications errors, abuse and accidents. Staff knew what incidents to report and they escalated incidents to the manager. All staff had received training on the new electronic reporting system, though not all had used it yet. The service had an incident reporting policy that confirmed staff roles and responsibilities for reporting incidents and the review process.

All staff, including childcare workers, attended weekly team meetings where incidents were discussed and learning shared.

Staff were open and transparent and described giving clients a full explanation when something went wrong. The service reviewed incidents for trends and lessons learned and took appropriate actions. For example, following a serious medicines incident the service had successfully created and communicated a clear approach to prevent the situation from reoccurring.

Good

Substance misuse services

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

Good

Assessment of needs and planning of care

We reviewed eight client files and saw that all clients had a named keyworker that was identified in their care file. Client folders were organised but used as a repository for all client information. This meant it was difficult to find pertinent information quickly; however, staff knowledge was not affected by this. The staff team attended thorough and complete handovers where up to date information was shared. Staff referred to the handover folder minutes for a quick overview of clients care and needs.

Seven, of the eight client files had a risk management plan but none of these included a plan for unexpected exit from treatment. Staff described how they managed a recent unplanned exit. They had contacted social services and given harm minimisation advice to lessen risk. Staff completed the early leavers pack which included written advice on safe coping skills, contact numbers and emphasised the effects of drug use on themselves and others. The service ensured that all children were safe if a parent left unexpectedly. Children were not allowed to leave with parents as this posed a risk to the child's safety.

Staff used a recognised assessment tool prior to and on admission to help clients identify goals that were incorporated into their care plan. This, in conjunction with the therapeutic community and group work, helped clients gain a better understanding of their behaviours and gain increased levels of personal and social responsibility. Most care plans reflected the needs identified during the assessment process and care plans were updated with client input; however, these were not always signed by clients.

Best practice in treatment and care

The service provided care and treatment interventions suitable for the client group based on recognised best practice guidance. The recovery model was a combination of the Therapeutic Community model and Cognitive Behavioural Therapy. Therapeutic Communities are structured, psychologically informed environments where social relationships, daily structures and different activities are deliberately designed and linked to help people's health and well-being. Cognitive Behavioural Therapy is a type of psychotherapy where negative patterns of thought about the individual and their world are challenged to alter unwanted behaviour patterns.Treatment included medication reviews, (when a client was part of the detoxification program) and implementing a consistent daily structure to help acquire living skills. The structure included duties around the house, group work, effective time management and establishing a routine for families. Clients attended daily therapeutic groups based on topics such as coping with cravings, responsible behaviour, emotion management, high risk situations, and problem solving. They completed set work such as the 'my life story' document that helped them to reflect on their behaviours and progress through the treatment plan stages. Clients also completed the accredited Triple P Positive Parenting Program. This intervention enhanced parents' self-sufficiency and self-efficiency in managing their children's behaviour. The nursery within the service provided care for clients' children in an outstanding rated OFSTED environment. This allowed parents to access the therapeutic program and have guidance on childcare and development from qualified childcare workers.

Staff supported clients to lead healthier lives. The service had good links with the Sheffield Sexual Health service who supported clients to become more educated around sexual health.Clients were able to attend a local gym and workshops relating to debt management, budgeting, cooking skills and child care skills. Staff also arranged for female clients to attend a local community group set up to support vulnerable women in the local area. However, three clients said that they would like to reduce or give up smoking but that they had not been given any advice on smoking cessation. The service told us that they were in the process of sourcing an external partnership to deliver smoking cessation to the clients and that they asked clients if they would like to stop at the point of assessment. If this was the case, staff would direct clients to their GP.

Clients were offered routine blood borne testing via their GPs.

The service had an IT suite that clients could use twice a week to access additional help for benefits claims as well as personal emails.

Monitoring and comparing treatment outcomes

The service had a well-structured approach to monitoring client outcomes. Client progress was monitored via the

recovery star outcomes model and family star at one to one keyworker sessions. Clients indicated how they felt they were progressing in their recovery on a pictorial, scaled star graphic. This included, for example, emotional and mental health, drug and alcohol misuse and motivation and taking responsibility. One to one sessions did not always occur weekly as detailed in the provider's local protocol. Staff and clients said that one to one session could be cancelled, if something was deemed a higher priority, for example a medical emergency. We identified staffing issues that may have contributed to the availability of staff for keyworker sessions. Clients found sessions being cancelled disruptive to their care. Staff recorded complete, comprehensive notes at these sessions however one discussion had not been updated in the client's care plan.

Staff also completed the Treatment Outcomes Profile (TOP) in their keyworker sessions. TOP is a simple set of questions for clients at various stages in their treatment journey and the data is reported through the National Drug Treatment Monitoring System (NDTMS). The NDTMS collects, analyses and publishes information from and for those involved in the drug treatment sector. This information allowed the service to benchmark its success against other services.

The service conducted internal quality audits and we saw that action plans were reviewed and updated. We were not assured that all completed actions, marked as complete, were complete.

Skilled staff to deliver care

The service offered staff personal development training. Additional training included courses in therapeutic communities, professional boundaries, outcome star training, drug and alcohol awareness, managing challenging behaviour, mental health awareness, facilitation skills and train the trainer courses. Staff were also able to request training not provided by Phoenix. For example, one staff member had recently had training approved to attend an external course relating to domestic violence.

The service provided all staff, including sessional staff and students, with a comprehensive induction. We reviewed five staff personnel files which included records of training, supervision records, annual appraisals and performance reviews. The service submitted data from July 2018 that showed that 65% of staff had completed their annual appraisal. This was because appraisals were not applicable to four newer staff members in their probationary period and two other staff members were on sickness or maternity leave. All staff had a named person that provided them with regular supervision.

When there were issues with staff performance these were addressed promptly and effectively.

Multidisciplinary and interagency team work

There was multidisciplinary input into the comprehensive pre-admission assessments completed prior to admission from the referring agencies and other professionals and services. Client's care plans showed involvement from GPs, maternity services, children and family services, social workers and criminal justice services.

The service held regular, effective handovers and team meetings that included childcare workers and adult workers. Information was shared well. All clients, including children, were discussed at handover and thorough minutes were kept so that all staff were informed. Handovers discussed client risks and a focus on clients' recovery was apparent throughout. Team meetings also followed a set agenda that covered previous actions, admissions, high-risk clients and safeguarding and governance agenda items like health and safety, policy, incidents, complaints and equality and diversity.

Clients followed a structured treatment plan for 12 or 24 weeks. Most placements lasted 12 weeks as this timeframe reflected the needs of the criminal justice system. The service worked with supporting services to ensure the safety of clients and their families when treatment ended, and clients were discharged back into their community settings. The service had also previously cared for clients for an additional period when a safe transfer of care could not be arranged.

The service worked well with other agencies to plan integrated and coordinated pathways of care to meet the client's needs. Staff had daily discussions with social workers and updated relevant parties, including referrers and care coordinators, with the clients' progress and needs.

Good practice in applying the Mental Capacity Act

The service had a policy on the Mental Capacity Act which staff were aware of and could refer to if needed. 88% of staff had completed the training and more intensive training was also available to staff as part of their personal

development. Staff members that had not completed the mandatory training, had it booked. Staff were also able to access the Phoenix Futures clinical quality manager for guidance if required.

Capacity was assessed as part of the referral process and staff assured us that if there were any issues with capacity then these would be addressed with the client's social worker before an admission. If a client was incapacitated during their assessment, then staff would rearrange the appointment. Clients records showed that they consented to care and treatment on admission.

Are substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

We observed most staff to be caring, compassionate and respectful. We attended a parenting group that was well facilitated and informative. Clients were offered practical and emotional support by staff and others in the therapeutic community. Staff considered the clients' needs in a holistic way. They helped clients to establish a daily routine, with defined responsibilities that encouraged and enabled parents to provide care to for their children alongside their own recovery, in a safe way.

We also observed a community meeting with a relaxed, friendly atmosphere. Staff supported clients to understand their condition and manage their care. Clients spoke positively about the program. They appreciated the support of staff and other members of the therapeutic community.

The service had clear confidentiality policies in place that were understood and followed by staff. Staff maintained the confidentiality of information about clients and clients were aware of their responsibilities regarding confidentially.

Staff directed clients to other services when appropriate and supported them to access those services, for example, mental health services or maternity care. The service had a 'bleeper' system in place to support clients during birth. This meant that one designated member of staff was on call and available to support a client during labour. Staff also encouraged clients to look after their health needs by encouraging then to access the local GP and dentist. The treatment program taught clients how to care for themselves and their families.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes without fear. Racist and bad language was not tolerated by staff or clients and that any occurrences were discussed and if appropriate, support, sanctions or warnings were given.

Involvement in care

Involvement of clients

Clients received a clear induction to the environment and the expectations of the service on admission. Staff explained the house rules, safety processes and used the buddy system to help orientate clients. They explained the different roles of staff in the service and introduced them to their keyworker.

Staff ensured that all clients understood the treatment provided, including those with communication difficulties. They offered additional time and support for clients who struggled with reading or writing and printed information on different coloured paper to help clients with dyslexia.

Clients were fully engaged and participating in their care and treatment. Personal information and histories were evident in care plans and group discussions. Families and carers were not always involved as this was not always appropriate. However, staff described families visiting clients and children in the service and families and carers spoked positively about the service.

Clients had support plans that detailed their preferences, recovery capital and goals. Clients identified goals using the outcomes tools and personal preferences were evident. For example, we saw clients accessing the local gym and local groups. However, support plans and client files did not always reflect the levels of personal knowledge and support given by staff. For example, there was evidence of a client making arrangements to move into new accommodation in daily handovers, but this hadn't been reflected in the client's care plan.

Staff engaged with people using the service, their families and carers to develop care that met their needs. They ensured they had information to make informed decisions about their care. Families of clients using the service felt informed and involved.

Good

Substance misuse services

The service encouraged clients to access external groups and advocacy for support. For example, a local community group set up to support vulnerable women in the local area. Staff could also signpost clients to appropriate groups depending on the type of advocacy required.

The service sought feedback from clients at business meetings, the service user forum and via questionnaires. A 2018 client questionnaire had highlighted that pre-admissions information was not always shared or understood by clients entering the service and that staff communication was not always consistent. However overall responses were positive, and clients felt supported. The service user forum was held every two months but there had been a gap in this feedback provision between December 2017 and July 2018. We reviewed the last two meeting minutes and saw that clients raised concerns about keyworker sessions and activities.

Clients also voiced some frustrations to us about keyworker sessions and leave not always being accommodated and spoke of an inconsistency in house rules being applied. This had also been identified in the internal inspection. Some clients felt that staff could be judgemental. Clients also said that there could be more activities on offer and a greater variety of family activities that were tailored to the children's ages.

We saw a 'you said, we did' poster that indicated service users had an overall satisfaction rating of 69%. This was within the adequate range identified by the provider. The 'we did' section of the poster said that all potential families would receive a copy of the service brochure prior to admission, the service would complete the ongoing room refurbishment program and re-establish weekly parent and child sessions.

Involvement of families and carers

Three clients consented to us contacting their families. Families said that they were involved in their loved one's care and that clients were encouraged to maintain and improve relationships with them. Families could see a positive change in their loved ones because of the treatment provided. They told us staff were welcoming when they visited, and that they were grateful that their relatives had the opportunity to be in the service.

There was no mechanism in place to collect carer or family feedback. However, the service had identified this and had created a questionnaire to send out to families and carers in December 2018. The service had also created a feedback form for families and carers to complete at the service's next recovery day. Feedback from carers was positive.

Staff told us that families and carers were given information about how to access a carer's assessment.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Good

Access, waiting times and discharge

The service had clear admission criteria and a dedicated member of staff to complete all preadmission checks. The preadmission process included working with the referrers, completing preadmission risk assessments, gathering medical records and completing criminal background checks. The manager would then contact the client and invite them to attend the service for a comprehensive assessment or complete this over the phone if the client was unable to attend in person.

If a client was not suitable or posed a risk to themselves or others, they were not accepted into the service. Referrals were accepted from anywhere within the UK from a range of agencies including, community substance misuse teams, probation and criminal justice services, child social care agencies and council services. The length of time from referral to admission varied depending on the availability of the information needed for the preadmission checks. This was because the service had to safeguard current users of the service.

The service followed a specific treatment program, therefore if a client was unable to comply with specific treatment requirements they would not be admitted to the service. If a client's need could not be met once in the service, staff worked with the referring agency to safely discharge them.

Discharge and transfers of care

Client folders included support plans and risk management plans that reflected the complex needs of the clients. There was evidence that staff worked with clients to facilitate

clear care pathways to other supporting services such as maternity, social, housing and community mental health services. Clients described getting ready for discharge and the support given.

Staff planned for clients' discharge, including ongoing working with care managers or co-ordinators throughout their stay. Discharge dates were identified alongside the referral and clients completed the planned discharge exit pack; this included harm reduction advice and details of their resettlement plans. The service program also prepared clients by having increased un-escorted leave entitlements with clear expectations so that clients could care for themselves and their children. We spoke with one commissioner who felt that transition planning could be improved. Although the service evidenced client's needs and progress during their stay, they felt that the service could provide more input and detail to a care plan for the clients' next steps following discharge.

Staff supported clients during referrals and transfers between services, for example, if they required treatment in an acute hospital or temporary transfer to a psychiatric intensive care unit. The service had implemented a dedicated bleeper on call system for clients that were admitted to hospital for labour and staff described supporting a client that was transferred to a psychiatric intensive care unit when their needs could not be safely managed in the service.

Between the 1 August 2017 to 31 July 2018 the service admitted 41 clients. 66% of clients completed the treatment program and 27% were transferred to other services. The remaining 3% were unaccounted for; this equated to 1 client.

Facilities that promote comfort, dignity and privacy

Each family had their own bedroom which they could personalise; they also had access to a shared kitchen and bathroom. Clients catered for themselves and their children, so snacks and drinks were available throughout the day. However, we observed that clients were not allowed any food or drink in their bedrooms.

Clients had a key to their room but said that they rarely locked their doors. Clients were able to meet with visitors in the lounge or their bedrooms if they wished. The service had a large garden at the rear with play equipment and seating areas. The service had a payphone that clients could use for 20-minute allocated slots between 4pm and 11pm in addition to the office phone. Clients could use the office to phone children and their care professionals.

Clients' engagement with the wider community

Staff supported clients to maintain contact with their families and carers. The service ensured that clients were able to speak with children that were not in the service and had flexibility for those children to visit. Other family members could visit every fortnight on the weekends. Staff individually risk assessed family visits because there was the potential that some visits would impact negatively on clients' care, for example when families also abused substances.

The service had links with external groups that clients could attend and encouraged clients to access mutual aid groups upon discharge. The service was in the process of re-establishing links with a local group that provided cooking on a budget classes and first aid courses to clients. These were previously provided but the local group had a change in management, so the classes had ended.

As well as the morning therapeutic activities, clients had access to activities such as relaxation group, yoga and a local gym. On evenings the service ran games nights, creative groups and peer counselling groups. However, clients felt that activities could be improved and more targeted to the children's age ranges. For example, except for one child, all children in the service were under one year old, so clients felt that trips to the park were not as beneficial as they might be for older children. We also saw that clients had fed back about improving activities in the 2018 client questionnaire. We queried what action had been taken with the provider who said they had since increased activities.

Meeting the needs of all people who use the service

The service was in an old building with no lift so clients with mobility issues could not be accommodated. However, staff described moving a client's bedroom to a lower floor when mobility became an issue, for example because of pregnancy or physical health conditions.

Staff offered support and demonstrated an understanding of the potential issues facing vulnerable groups such as lesbian, gay, bisexual and transgender clients (LGBT), black and ethnic minority clients (BME), and people experiencing

domestic abuse or that had worked in the sex industry. Staff gave examples of supporting clients when they liaised with the police. The service fully supported pregnant women through engagement with antenatal service, pregnancy scans, arranging doulas and breast-feeding support groups. A doula is a non-medical person who assists a woman before, during, or after childbirth, to provide emotional support and physical help if needed. They also may provide support to the mother's partner and family. Staff also helped clients access child benefits, tax credits and healthy start vouchers.

The service could arrange translation services as needed and course content could be adjusted to include any specific cultural needs. For example, shopping trips to Polish, Asian or Caribbean shops, hair dressers or places of worship.

The service did not have a waiting list and was dependent on completing all safety checks before clients could be admitted for care.

Listening to and learning from concerns and complaints

All clients knew how to complain and felt comfortable doing so. Information on how to complain was provided on admission, and complaints slips, and feedback boxes were available in communal areas. The provider had a clear complaints process that detailed the timeline for the complaints investigation and the escalation procedure. Staff listened to clients who raised concerns or complaints and protected them from discrimination and harassment. Clients told us that complaints were acknowledged and responded to. We saw that clients raised concerns at business meetings and in groups and these were recorded in the handover notes.

Between August 2017 and July 2018, the provider recorded three formal complaints. Of these, two were resolved within seven days and the other within 21 days in line with the complaints policy. Where complaints related to staff attitude, these were recorded and addressed with staff members involved. The service also received five compliments during the same period.

Are substance misuse services well-led?

Good

Leadership

Managers in the service had the skills, knowledge and experience to perform their roles. The service had recently employed a qualified social worker as program manager and a separate childcare manager who oversaw the nursery and childcare provision. These functions, combined with the experienced registered manager, offered expertise that met the needs of the clients and staff. As well as mandatory training, managers had access to role specific training such as budgeting, leadership and management, managing sickness and audit.

Leaders had a good understanding of the services they managed. They could clearly explain how the teams were working to provide high quality care. They were able to accurately describe staff roles and responsibilities in line with the service's protocols. Clinical leadership was provided by the organisation's clinical quality manager. They provided clinical supervision to the nursing staff in the service.

Managers were visible, and clients and staff said that they were approachable. Senior managers from the Phoenix group also visited the service and held regular one to ones with the registered manager of the service. The head of quality and director of operations provided additional support to staff when the registered manager was on annual leave and the chief executive officer had visited the service. All staff in the service had a clear understanding of recovery and the service's approach.

Vision and strategy

Staff knew and understood the vision and values of the organisation and what their role was in achieving that. Values were included in staff induction and the vision and values of the service were visible in the lounge. Staff told us they felt connected to the company.

Senior managers in the organisation held an annual corporate roadshow where they gathered staff opinion and shared information about the organisation's business plan and future strategy. In 2018, senior managers had launched a new strategy specific to the residential services. One member of staff described being informed about the

Purple Camel Project. The project was a new social enterprise initiative led by clients within the Phoenix organisation who were growing their own fruit and vegetables to sell in the future.

The managers were aware of financial risks to the service, such as overarching cuts to substance misuse service budgets, however worked hard to deliver high quality care. The manager had provided extended client care free of charge when other agencies would not.

Culture

Staff felt proud to work for the provider and told us they felt valued and respected. They were a close, supportive team that worked well together. Staff completed annual staff satisfaction surveys commissioned by an independent provider; results were reported at provider level and not at the individual service level. Staff said that although the work was sometimes stressful, they felt supported by their immediate managers and each other. In 2018, Phoenix Futures achieved a position of 54th in the Sunday Times Top 100 not-for-profit organisations to work for.

The provider held an annual staff awards ceremony where staff could nominate colleagues for awards. The chief executive officer sent a newsletter round every quarter to all staff where individual and team achievements were recognised. Staff had access to employee assistance programs and could access independent support for their own health and well-being via a telephone helpline. They also had access to practical support and counselling through the scheme. Managers spoke with staff in supervision and appraisal about their overall well-being and career development and had training provision to support their development. This also offered the service an opportunity to monitor staffs' job satisfaction and morale.

Staff reported that the provider promoted equality and diversity in its day to day work. Equality and diversity was standing agenda item at team meetings and induction and the service had a policy that detailed the organisational approach and staff responsibilities.

Between the period August 2017 to July 2018, the provider reported no cases of bullying or harassment. Staff knew how to raise concerns and felt able to do this without fear of retribution. Staff felt that they could raise concerns with their direct line manager or other senior staff members. Phoenix had a corporate human resources department to support managers with staff underperformance. We saw that they carried out investigations, offering an unbiased view, and that the service used defined performance management processes with staff when appropriate.

Governance

The service followed an effective and clear framework to share information. Team meetings, supervisions and handovers had a set agenda that ensured that staff were kept informed of essential information such as client risk and learning from incidents or complaints.

On a quarterly basis, the director of operations met with the registered managers to discuss operational issues and key performance indicators. The operations director then reported issues through to the Board via quarterly clinical governance meetings.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the clients. The service worked well with external stakeholders and shared information and concerns regularly.

Governance policies, procedures and protocols were regularly reviewed and improved however policies did not include an equality impact assessment. An equality impact assessment is a process designed to ensure that a policy, project or scheme does not discriminate against any disadvantaged or vulnerable people.

Staff undertook medicines and quality audits. The Phoenix Futures quality team had carried out a quality check of the service in July 2018 and had identified one to one frequency as an issue. In response the service had created an overall quality improvement plan. The action relating to keyworker sessions had been marked as complete in September 2018. Although there were some improvements, we did not find this to consistently be the case. The service had identified risk assessments as an area of improvement, so they had introduced peer reviews of client's folders. We saw that actions marked as complete on the service's continuous improvement plan had not been fully rectified. However, we also saw that there had been improvements in these areas and that the service was taking steps to resolve them. The director of operations explained that the head of quality would re-visit service improvement plans when they carried out subsequent audits and would highlight any ongoing concerns to the relevant managers.

Although monitoring of staff training had improved, we saw that this mechanism was not fully embedded; the compliance figures did not include night staff and the manager did not have oversight of the training compliance figures during the inspection. We saw that sessional staff had not completed all the required training.

We struggled, as did staff, to have clarity on the expectations surrounding night staffing. All staff, including senior managers said that the service provided waking staff. However, the rotas showed that this was regularly not the case. The lone working risk assessment identified that having sleeping staff was acceptable when waking staff could not be provided. The lone working risk assessment also identified that all staff lone working should have managing challenging behaviour training, however we saw that only 59% of sessional staff and 50% of therapeutic staff had completed this training. This training was not determined as mandatory by the provider. The service said that they ensured that only trained staff lone worked, but the limited training oversight was a concern in this respect.

Management of risk, issues and performance

The service had a business plan in place for emergencies, for example if there were issues with severe weather or issues relating to accommodation. We found no examples of cost improvements compromising client care.Staff didn't raise any concerns with us; they were a happy staff team who felt valued. They felt able to raise and resolve any concerns they had between the staff team and felt empowered to whistleblow if needed.

There was a clear quality assurance management and performance framework in place that was integrated across all organisational policies and procedures. The service had clear policies and local protocols. The provider monitored performance and had service level improvement plans in response to a recent internal inspection.

Staff also listened to client feedback and had plans in place to address them, but the service did not have an overarching plan that included these. This would have provided total oversight of how the service were managing all issues. We saw that some items identified on the actions plans, for example risk assessments, had been identified and marked as complete when they were not yet fully resolved. The service was fully aware of, and had mechanisms to, monitor sickness and absence; senior leaders in the organisation had been made aware of staffing shortfalls including night staff vacancies.

The service did not have its own risk register; instead risks were identified on the corporate risk map. The risk map identified the potential of risks not meeting the corporate strategic objectives; these were fully aligned with the provider's vison and values. Risks included funding and budgets, client complexities and policy changes. Managers did not have a service level risk register but said they would be able add items to their organisational register through discussion with senior leaders.

Information management

The service used an accessible electronic information management system that allowed managers to collect data and analyse performance. Managers regularly reviewed key performance indicators and accessed quarterly data regarding bed occupancy, planned exits, staff sickness levels, staff vacancies and financial performance for improvements.

The service had clear processes to ensure clients confidentiality, including the sharing of information, and these agreements were explained, consented to and recorded in client folders. The service shared information and notified other services when appropriate. This included the Care Quality Commission, police, courts, schools and local authorities.

In March 2019 the provider will be extending the functionality of the electronic information management system to include electronic care records for clients, in line with the other Phoenix services. The current care record system was paper based and although it was not always easy to locate specific information, staff were informed of individual clients' needs and risks. Paper files were secured, and staff had password protected access to IT systems that supported them in their roles.

Engagement

Staff received fortnightly newsletters that shared information about the work of the provider; these were sent by the Phoenix corporate team. Staff also had access to an intranet where up to date information and policies were available. Staff told us they felt informed.

Clients gave feedback about the service during daily discussions. They could also use the suggestion boxes, service user forum and group meetings if they wished. The service sought feedback from clients via questionnaires and satisfaction surveys.

Good

Substance misuse services

The service had a new service user involvement strategy and the provider was planning a range of projects to help bring together the voices of people affected by addiction and those working towards a more recovery friendly society. We saw leaflets in the service advertising how clients could get involved and links to a social media campaign.

Service managers and staff worked with commissioners and external stakeholders from receipt of the referral until discharge. One commissioner described them as a responsive and flexible service.

The service did not currently have any formal way to capture and measure carer feedback, but the manager planned to roll out their newly developed questionnaires in December 2018. Carers we spoke with were positive about the service, the treatment and staff.

Learning, continuous improvement and innovation

The organisation encouraged creativity and innovation to ensure up to date evidence-based practice was implemented and embedded.

The service had good links with local universities. They had contributed to a study completed by Sheffield and Hallam University which reviewed the effectiveness of the therapeutic community model against community-based services and were regularly approached by students to complete placements and contribute to masters projects.

In 2017, Phoenix Futures worked with the BBC to produce a television documentary that showed daily life within the family service. The service hoped that the documentary gave insight into the experiences of their clients and service and reduced social stigma.

Learning, recognition and improvement was evident in staff interaction and practice. Staff had individual objectives in their annual appraisals which managers reviewed regularly in supervision. The provider also had an annual awards scheme and a newsletter where individual staff would be mentioned if they had any notable achievements.

The service had been awarded a five-star rating by the European Foundation for Quality Management (EFQM). This award recognizes European businesses that achieve excellent and sustainable results using their quality assurance framework.

The service's new appointment of a qualified and experienced social worker as program manager meant that the service was able to offer parenting assessments for use in court. The service had also recently contributed to a review held by the family drug and alcohol court regarding the referrals process.

The service also held a gold Investors in People accreditation. Investors in People was developed as a national standard of good practice for training and development.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must have effective mechanisms to provide complete oversight of all training required by staff to complete their roles.

Action the provider SHOULD take to improve

- The provider should ensure that staff shortages do not impact on activities, leave agreements or client key working sessions as identified in local policies and procedures.
- The provider should ensure that all client files including risk assessments, care planning and crisis plans reflect the personal knowledge held by staff. The provider should ensure that documentation in client care files are individualised and updated in a timely way.
- The provider should consider using a formalised structure to continually review and justify the rules within the service. The service should ensure that the application of house rules is consistent.
- The provider should continue to ensure that quality checks are conducted in relation to the service's continuous improvement plan and that the improvement plan identifies and details all the work that the provider is doing.
- The provider should continue to implement formal mechanisms to obtain carer feedback and involvement.
- The provider should consider the inclusion of an equality impact assessment in all policies and protocols.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The service did not ensure that persons providing care or treatment to service users had all the required training. This was a breach of regulation 12 (2)(c).