Transforming Choice CIC

Quality Report

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

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

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

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

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

Overall summary

We do not currently rate independent standalone substance misuse services.

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

- Staff were not recording the administration of a high-dose vitamin injection, individual sessions with the academic psychologist and some health and safety checks.

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

- Clients were truly respected and valued as individuals. Staff treated clients with dignity, respect and compassion. Clients were empowered as partners in their care and actively involved in service development.
- The service accepted vulnerable people who might be excluded from other residential treatment programmes. Staff planned for discharge in the first few weeks of clients' stay (including supporting clients to find appropriate accommodation). Staff gave clients accessible information about the service and how to complain.
- Clients completed their own recovery-oriented care plans. Clients were involved in reviewing the

Summary of findings

effectiveness of their own treatment. Staff considered the Mental Capacity Act when working with clients who were intoxicated. There were measures in place to ensure that clients gave informed consent to admission.

- The building was generally warm, pleasant, clean and tidy. There were enough staff to keep people safe. Care records included a comprehensive risk assessment. There was clear guidance for staff to follow if they had concerns about clients' safety.
- Managers and staff were passionate about working with vulnerable people, and believed in the potential for recovery. There was a board assurance framework, risk register and plan to improve clinical governance. Staff were engaged and involved in service development. The service reported on outcomes for each individual client.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services		See overall summary.

Summary of findings

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Transforming Choice CIC

Services we looked at:
Substance misuse services

Summary of this inspection

Background to Transforming Choice CIC

Transforming Choice CIC is a community interest company offering alcohol detoxification and residential rehabilitation for people recovering from substance misuse. It provides care, treatment and support to help clients reintegrate into communities. The service is unusual in that alcohol detoxification is carried out using alcohol drinks. Staff give clients a set number of units to drink each day, until the client has completely withdrawn from alcohol. The residential rehabilitation programme is similar to that provided by other services. It focuses on building coping strategies and life skills. There is also an aftercare service that consists of a member of staff who continues to support clients who have been discharged from the residential programme.

There is a contract in place with a general practitioner and nurse from a local practice. They assess clients' medical needs and administer high dose vitamin injections to assist with detoxification.

The service was registered to provide the regulated activity accommodation for persons who require treatment for substance misuse. It was registered on the 5 March 2015, and had a registered manager. The service was limited to only provide the regulated activity for a maximum of 14 clients at any one time. There were 13 clients at the time of inspection, who had been in the service for two weeks. The service was available to men and women aged over 18 years. The length of the treatment programme was three months and clients could not join the programme after it had started. The service accepted four cohorts of 14 clients per year.

There were a further eight bedrooms on the top floor of the property. These eight bedrooms were rented to people on a short-term basis, and were not subject to inspection by the Care Quality Commission.

At the time of inspection, all residential and aftercare places at Transforming Choice CIC were funded by two charitable trusts. Local authorities did not commission the service, but had spot purchased individual placements.

Our inspection team

The team that inspected the service comprised CQC inspector Rachael Davies (inspection lead), one other inspector, a pharmacist inspector and an inspection manager.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme to make sure health and care services in England meet the Health and Social Care Act 2008 (regulated activities) regulations 2014.

How we carried out this inspection

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

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

Summary of this inspection

- Is it well led?

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

During the inspection visit, the inspection team:

- visited the service, looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with nine clients
- spoke with the registered manager
- spoke with four other staff members employed by the service provider
- attended and observed a hand-over meeting and a group education session for clients
- looked at seven care and treatment records, including medicines records, for clients
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

Clients told us that they felt safe at the service. They described staff as caring, respectful, friendly and compassionate. Clients were very positive about the support and treatment they had received. They said there should be more places like Transforming Choice CIC.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The building was generally warm, pleasant, clean and tidy.
- There were enough staff to keep people safe and provide appropriate activities.
- Care records included a comprehensive risk assessment.
- Health and safety and fire risk assessments were up to date.
- Male and females did not have to share bathrooms.
- All staff had received and were up to date with mandatory training.
- There was clear guidance for staff to follow if clients had a seizure.
- Staff knew how to make a safeguarding alert.
- Staff used local processes to record and communicate incidents.

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

- Not all care records included an individual risk management plan.
- A number of needles in the service's anaphylactic shock kit were out of date.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff completed a thorough assessment of clients' needs.
- All of the records that we reviewed contained up-to-date, recovery-oriented care plans that had been completed by clients.
- Staff used clients' alcohol consumption, weight and physical health information to calculate individual alcohol reduction plans.
- Care records were stored securely, and were accessible to staff who needed them.
- The service demonstrated positive outcomes for individual clients.
- The content of the residential rehabilitation programme was in line with best practice guidance.
- The service promoted clients' autonomy and responsibility.

Summary of this inspection

- The service used the recovery star (an outcome measurement tool) with clients to ensure that they were involved in reviewing the effectiveness of their own treatment.
- Staff were experienced and qualified.
- Staff received supervision at least once every three months.
- Handovers between shifts were effective.
- Staff considered the Mental Capacity Act when working with clients who were intoxicated, and took steps to ensure clients gave informed consent.
- Clients consented to restrictions, which were proportionate and in line with the aims of the service.
- The service had good links with local homeless charities and housing providers.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients were truly respected and valued as individuals.
- Clients told us that staff were always polite, caring and compassionate.
- Staff showed empathy and understanding in relation to clients' histories and circumstances.
- The pre-admission and admission process involved input from a peer mentor.
- Clients were empowered as partners in their care.
- There was a strong, visible person-centred culture.
- The service actively sought and used client feedback to improve.
- Staff showed determination and creativity to overcome obstacles to delivering care.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The service accepted vulnerable people who might be excluded from other residential treatment programmes.
- There was no waiting list for the service.
- Clients had plans in place for discharge.
- Staff ensured that clients had somewhere safe to go if they left treatment early.
- The facilities at the service promoted recovery, comfort, dignity and confidentiality.
- Clients chose their own food and could access drinks and snacks throughout the day.

Summary of this inspection

- Staff provided activities seven days a week.
- The ground floor of the building was accessible to wheelchair users.
- The service provided accessible written information to clients.
- Clients were given information about how to complain.
- The service had taken action to resolve informal complaints.

Are services well-led?

We do not currently rate standalone substance misuse services.

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

- Administration of a high-dose vitamin injection, individual sessions with the academic psychologist and some environmental health and safety checks were not recorded.
- Reports of clients' progress did not include a clear summary of outcomes that the provider and commissioners would be able to use to compare against previous cohorts or other services.
- Risk registers were not discussed at all senior management and board meetings.

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

- Managers and staff were passionate about working with vulnerable clients, and believed in the potential for recovery.
- Staff morale was good.
- Staff shared the organisation's vision and values.
- Managers were visible in the service and on first-name terms with staff. Staff described managers as caring and supportive.
- Governance structures ensured that there were sufficient skilled and experienced staff.
- The service provided a three monthly 'cohort report' for funders, which mainly consisted of qualitative information from clients about the progress they had made.
- There was a board assurance framework and risk register, which covered organisational and operational risks.
- All staff (including volunteers) were able to add items to the risk register.
- The clinical governance structure provided a framework for quality improvement, clinical audit and staff development.
- Staff were engaged and involved in service development.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff followed the principles of the Mental Capacity Act when working with clients who were intoxicated. Staff took appropriate measures to ensure that clients gave informed consent to admission. There were no clients subject to Deprivation of Liberty Safeguards.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

Transforming Choice CIC was based in a large house in a residential area of Liverpool. Fourteen bedrooms and a number of shared living rooms, bathrooms and kitchen facilities were available for clients requiring treatment for substance misuse. All fourteen bedrooms were single occupancy. One bedroom had an ensuite bathroom; all others included washbasins. Female and male areas were segregated and included female-only or male-only toilets and showers. Windows on the upper floors had restrictors to reduce the risk of falls. There were staff call buttons in each bedroom so that staff or clients could summon assistance if a client had a seizure at night.

The service had health and safety, fire risk and legionella risk assessments completed by external contractors. All were up to date. Certificates were in place to show that gas and electrical appliances had been serviced and tested. Three of the staff had been trained as fire wardens, and fire evacuation drills took place once every two months. Staff told us that they undertook regular checks of fire alarms, water temperature and first aid boxes. They said that they also flushed unused water outlets to prevent legionella. We looked at three of the service's seven first aid boxes. They were fully stocked with items in date. However, staff could only provide documented evidence of the fire alarm checks. There was no record of the water temperature or first aid box checks, or of the water outlets being flushed. The service had an anaphylactic shock kit for use in an emergency. We found that a number of needles in the kit had been kept after their expiry date, which meant that their sterility could not be guaranteed. Staff disposed of the needles during our visit.

The service did not have an environmental ligature assessment. A ligature point is something to which a person intent on self-harm might tie something to strangle themselves. The service had considered that an environmental ligature assessment was not needed, as clients were assessed as not at high risk of suicide.

The building was generally warm, pleasant, clean and tidy, although there were some slight traces of mould in some of the showers. Furniture and decoration was well maintained. Clients were responsible for cleaning their rooms and the communal areas. They developed their own cleaning schedule, which showed that tasks had been completed. Staff cleaned the main kitchen and did a 'deep clean' of the rest of the service during the time between one group of clients being discharged and the next group admitted. Cleaning products and equipment were kept in a locked room. There were clearly labelled different coloured mops and buckets for different areas. This was a good practice to discourage people from using the same mop to clean bathrooms and kitchens. However, the locked room did not contain a list to enable staff to keep track of the location of substances potentially hazardous to health.

Safe staffing

There were nine full-time and one part-time paid staff employed by the service: a registered manager, an assistant manager, two caseworkers, an aftercare coordinator, four support workers and an academic psychologist. The academic psychologist was part-time. There were no staff vacancies. The service used two regular agency support workers to cover staff leave and sickness (46 shifts between September 2015 and September 2016). There was a contract in place with a local general practitioner and general nurse, who oversaw clients' physical health needs and administered high-dose vitamin injections.

There were also six peer volunteers working at the service. Five of the volunteers had successfully completed the programme at Transforming Choice CIC and maintained

their recovery from substance misuse. Public Health England recommend that substance misuse services employ peer volunteers, as they provide support, encouragement and proof that recovery is possible. The other volunteer was a psychology student. Volunteers received training and supervision from other members of staff. They did not have access to the staff office and did not take any responsibility for client risk assessment, risk management or care planning.

Staff told us and rotas confirmed that there were always at least two members of staff on site, including at night. One of the two managers would also be on site during the day from Monday to Friday and on call the rest of the time. Clients told us that staff were always visible and available to provide support. Therapeutic groups and activities were never cancelled because of lack of staff.

All staff had received and were up to date with mandatory training. This included training in first aid, safeguarding children and vulnerable adults, risk assessment and medicines management.

Assessing and managing risk to clients and staff

We reviewed seven client care records; four for current clients (who had been at the service for just under two weeks) and three for previous clients (who had completed treatment). The service's standard referral form was completed for each client. This meant that staff were able to review important information, including medical needs, alcohol and drug use, and offending history, before deciding whether the client could be safely cared for at Transforming Choice CIC. However, there was no section on the referral or admission form for clients' allergy status. This meant that staff had to remember to complete this with clients, which could increase the potential for error.

All seven care records included an initial risk assessment, which staff had completed on admission. The service used their own risk assessment tool, which rated clients' risks under a number of headings including self-harm, bullying, mental health, blood-borne viruses, aggression, medical conditions, seizures and neglect. Risk assessments had been reviewed weekly for clients who had been at the service for more than two weeks. Five of the seven records included a risk management plan, which stated how the areas of need identified in the risk assessment should be met. Two records did not include a risk management plan. This meant it could be difficult for staff working with those clients to know how to support them safely.

Acute withdrawal from alcohol can be dangerous for people with severe alcohol dependence. It can lead to seizures, delirium tremens, and in some instances death. Delirium tremens is a rapid onset of confusion, anxiety, tremors and hallucinations. The service had a protocol in place to help keep clients safe during alcohol detoxification. Clients' general practitioners supplied recent blood results and a letter prior to admission stating that the client was suitable for alcohol withdrawal detoxification. For the first ten days of the programme, clients stayed in communal areas during the daytime which meant that they could easily be observed by staff. Staff closely supervised each client's consumption of their daily allocation of alcohol. At night, staff observed clients in their bedrooms every fifteen minutes. Staff had received additional training in management of seizures. There was a policy that clearly stated how staff should support a client during and after a seizure (including when to call for an ambulance). Clients known to have damaged nervous systems were given bedrooms downstairs so that it would be easier to get to them if they needed emergency help.

The service had a safeguarding policy. Staff had received training in safeguarding and knew how to make a safeguarding alert. There was a flow chart on the wall of the office showing staff what to do if they were concerned. It included telephone numbers for the local authority safeguarding team. There was also a policy on managing aggression. Staff did not restrain clients. There had been no incidents of clients threatening or harming staff or another client since the service opened.

There was not a formal child visiting policy. Staff told us that, if children visited a client, they would sit in the garden. The service did not accept clients with a history of sexual offending.

There was an up to date policy for medicines management, but it was not specific to the location. There was a detailed protocol on management of controlled drugs. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. Medicines were stored securely in clients' rooms. Excess stock was held in dedicated locked lockers and a controlled drug cupboard if required or in a fridge in the

staff office if it needed to be kept at a low temperature. All staff had basic training in medicines management, and one member of staff had additional training. Staff recorded when medication had been given and completed a daily audit of controlled drugs. Each client had a risk assessment form and action plan for their medicines, which was detailed to meet their needs. However, in two of the five records we checked, we could not find documentation of quantities of medicines received upon admission. This meant there was no way of auditing compliance for those clients. We also found that the nurse did not make entries in clients' care records to show when a high dose vitamin injection had been given. Patient group directions were not dated, version controlled, signed or authorised. Patient group directions are written directions allowing non-doctors to assess people and supply medicines without prescriptions. We brought this to the attention of staff during our visit and this was rectified.

Track record on safety

The service had not reported any serious incidents between September 2015 and September 2016. One person who had self-discharged had later died from causes unrelated to their use of the service.

Three of the 109 clients that had used the service since it opened had experienced a seizure on the premises. None of the seizures had resulted in a lasting adverse impact on clients.

Reporting incidents and learning from when things go wrong

There was an up to date accident and incident reporting policy and procedure. Staff knew how to make reports. Staff told us about incidents that had happened, for example previous clients' seizures or a previous client going missing. They explained action that the service had taken to reduce the risk of these things happening in future. For example it was identified that one client had a seizure after another client took and drank their alcohol. Staff then agreed to supervise all clients when they were drinking. Staff also told us that they had met for a debrief and group support following the death of the ex-client.

Duty of candour

The duty of candour is a requirement for providers to be open and transparent with people when things go wrong. The service had an up to date duty of candour policy and procedure. There had been no accident or incident at the service that met the requirement for duty of candour. Staff were aware of the importance of being honest with clients and said they would apologise if something went wrong.

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

Assessment of needs and planning of care

We reviewed seven client care records; four for current clients (who had been at the service for just under two weeks) and three for previous clients (who had completed treatment). Each file contained a thorough assessment of clients' alcohol consumption and dependence, any alcohol related problems, other drug misuse, physical health, mental health, social problems and motivation to change, along with a brief assessment of cognitive functioning and a medical summary. This was in line with National Institute for Health and Care Excellence recommendations (Clinical Guideline 115: Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence). Clients' own general practitioners provided a print-out of clients' medical histories, diagnoses and medication. This would then be reviewed by the local general practitioner who held a contract with Transforming Choice CIC.

Staff used clients' alcohol consumption, weight and physical health pre-admission to calculate an individual alcohol reduction plan. Clients would then be given a set number of alcohol units to drink (usually sherry or strong lager) in the presence of staff up to four times a day. Clients received high dose vitamin injections for the first five days of their detoxification. We reviewed detoxification plans for four clients in detail. For these clients we saw that the first three or four days were used to stabilise the individual, with the dose then gradually reducing over the following few days. There was scope within the plans to give additional units if clients showed symptoms of withdrawal. Three of the four clients completed their detoxification on day six, with the fourth completing on day seven. Staff told us that detoxification for clients with liver problems could take up to ten days. Clients' detoxification plans were kept in separate folders and staff signed to show when alcohol had been given. However, there was no evidence in the service's documentation that vitamin injections had been given.

Substance misuse services

All of the records we reviewed contained up-to-date, recovery-oriented care plans that had been completed by clients. Clients were able to highlight areas important to them (for example relationships, alcohol and drugs, physical health, and mental health), state their desired outcome and identify potential barriers. Care plans set out the roles and responsibilities of clients and key workers. There were sections on 'personal solutions to deal with relapse'. We saw that this was more detailed for clients who had been in the service longer, which showed that clients were using skills that they had learned on the programme.

Paper care records were locked in filing cabinets in the staff office when not in use. Staff were able to access the information they needed to be able to deliver care. Volunteer peer mentors did not have access to care records. This was because peer mentors did not need to know clients' full histories and circumstances to be able to fulfil their roles.

Best practice in treatment and care

The team at Transforming Choice CIC had designed their alcohol detoxification service from their own experience of providing services and from client feedback. Guidelines published by the National Institute for Health and Care Excellence and Public Health England do not report on the effectiveness of detoxification programmes that use alcohol rather than prescribed medication to manage withdrawal. There are some published studies of similar alcohol reduction programmes that have shown positive results, but the evidence base is very small. This meant that it was important for Transforming Choice CIC to demonstrate positive outcomes for clients. All of their 109 clients had successfully completed the detoxification element of the programme, and 75% completed the full three months. Only 62% of clients successfully exit alcohol treatment programmes nationally (Public Health England: Adult substance treatment activity in England 2015-16). The service routinely collected qualitative feedback from clients; many reported that they had found the alcohol detoxification much easier than previous detoxifications where prescribed medication had been used.

The residential aspect of the service was consistent with best practice guidance from the National Institute for Health and Care Excellence and Public Health England. There was a weekly structured activity programme, which included education about addiction and relationships, mindfulness practice and basic cognitive behavioural strategies. Clients attended as a group, which meant that they were able to engage in mutual aid (sharing experiences and supporting each other). Peer volunteers provided evidence that recovery was possible and sustainable. We observed a psychology education session. All of the clients were interested and engaged.

The academic psychologist also offered individual sessions to clients. These were not documented, which potentially put the psychologist and client at risk if the content of discussions ever needed to be checked or shared.

The service promoted autonomy and responsibility in their clients. If additional physical health, mental health or social needs were identified the client was encouraged to make their own appointment with the relevant community service. Staff provided the minimal assistance necessary (for example, giving the client the telephone number for a dentist so that they could make the call themselves). Clients' additional needs were discussed with them in regular one-to-one sessions, which enabled staff to monitor whether needs were being met and offer additional support if they were not.

The service used the recovery star (an outcome measurement tool) with clients to ensure that they were involved in reviewing the effectiveness of their own treatment. At weeks six and 12 clients were encouraged to write letters to themselves to reflect on their progress.

Skilled staff to deliver care

Staff were experienced and skilled. Three staff had additional qualifications in counselling, one had additional qualifications in medicines management and one had additional qualification in safeguarding. Many had experience of substance misuse and rough sleeping, which helped them build trusting relationships with clients. The nurse visited the service for two hours, five days a week to administer high dose vitamin injections at the start of each cohort's treatment programme. The general practitioner visited to complete health reviews and attend managers' clinical meetings. At all other times, clients' medical needs would be met by their own general practitioner or other local NHS services.

The academic psychologist provided staff with training on psychological theories of addiction and relationships. Staff had also had additional training about the prevention of drug and alcohol related harm, including the transmission of blood-borne viruses.

Substance misuse services

All staff received supervision from a more senior member of the team at least once every three months. The academic psychologist offered additional pastoral supervision to help staff reflect on their emotional response to clients. All staff had had an annual appraisal.

There was a policy in place for poor performance. There was no evidence of staff misconduct, and no disciplinary action taken.

Multidisciplinary and inter-agency team work

The team at Transforming Choice CIC met once a week to discuss each client's care and progress. They also met for handovers between shifts three times a day. We attended the afternoon handover during our inspection. The handover was effective. Staff discussed each client's mood and engagement with activities. The deputy manager helped staff to develop a shared understanding of the reasons behind each client's feelings and behaviour, with reference to their history. This led to the generation of potential solutions or ideas for support (for example using 'the list of feelings' to help a client express themselves). Staff spent additional time considering clients' physical health needs to ensure they were being met.

The care records we looked at included evidence of liaison with clients' general practitioners. We did not see any evidence of liaison with other agencies (for example local authority, community mental health teams), which may have been because these clients did not have links to those agencies.

Adherence to the MHA (if relevant)

The service did not admit clients who were detained under the Mental Health Act. None of the clients at the service at the time of inspection were subject to a community treatment order.

Good practice in applying the MCA

Staff had not had specific training in the Mental Capacity Act. However, the Act was referred to in the service's policies and staff showed a good understanding of the principles and how alcohol and drug use might impact on clients' capacity. All potential clients were invited to the service for a tour of the building, assessment with staff and a meeting with a peer mentor. If clients arrived and were intoxicated, they were offered the use of a room to sleep and sober up. They were given a leaflet about the service to read in their own time, then invited back for a meal with staff and other potential clients. We saw that care records included an induction form signed by clients agreeing to the terms of admission. Staff told us that they would go through this form when clients were first admitted, but ask them to sign it when they were sober. This meant that clients were being appropriately supported to make their own decisions and give informed consent to treatment.

The service did not accept clients with cognitive impairments or disorders that permanently impaired capacity to consent to admission.

Equality and human rights

The registered manager told us that she had chosen the location of the service because it was in an area of Liverpool not strongly associated with any particular ethnic group. The manager hoped that the service would therefore be more easily accessible to people of different backgrounds.

There were restrictions in place, which were proportionate and in line with the aims of the service. Clients could not leave the premises without a staff escort for the first four weeks of their stay. Clients could not bring alcohol or street drugs onto the premises and could only drink alcohol as part of the supervised detoxification programme. Staff searched clients' bags on admission and when they returned from shopping trips. They stored clients' sharps in a locker until they left the service. Clients were only able to have their mobile phones on weekdays between 5pm and 9pm and at weekends. Staff explained that the restriction on mobile phones had been requested by a previous cohort and had been put in place so that clients could focus on the group treatment programme.

Clients were asked to give their post office or bank cards to staff; this was so that they would need to approach staff if they wanted to leave treatment. Staff told us that this provided an opportunity for clients to talk problems through rather than acting impulsively. It was not compulsory for clients to give their post office or bank cards to staff, and staff did not attempt to prevent clients from leaving.

Clients were informed of all restrictions before they decided whether to agree to admission. We saw from clients' care records that they had signed their consent to the restrictions.

Substance misuse services

Management of transition arrangements, referral and discharge

The service had good links with a local homeless and housing charity and a number of community substance misuse services. This enabled staff and clients to coordinate other sources of support well in advance of discharge from the residential programme. There was a laptop available for clients to use to register with a local housing organisation and bid for properties. The service offered short-term rental of rooms on the top floor of the property to people who were struggling to find accommodation.

The service also had an aftercare coordinator, who maintained contact with clients who had been discharged. The aftercare coordinator continued to liaise with other services on behalf of ex-clients. This meant that clients' extra health and support needs were met after treatment as well as during treatment.

Are substance misuse services caring?

Kindness, dignity, respect and support

Feedback from clients was very positive. Clients told us that they felt safe in the service as they knew that aggression would not be tolerated. They said that staff were always available to speak with. They described staff as respectful, polite, caring and compassionate. Clients said that it was amazing that staff were doing so much to help them. One client said that they felt that they were getting the treatment they needed, and that there should be more places like Transforming Choice CIC.

There was a strong, visible person-centred culture. We observed a group education session for clients and an afternoon handover meeting for staff. During the education session, we saw staff treating clients with dignity and respect. Staff valued clients' opinions. The facilitator (the academic psychologist) addressed each client by name and encouraged participation.

It was evident during the handover meeting that staff had a thorough understanding of clients' individual needs. All staff showed empathy in relation to clients' histories and circumstances. Staff used the information clients had given them to develop a shared understanding of what clients might struggle with, and what could be done to help them. They took clients' personal, cultural, social and religious needs into account.

The involvement of clients in the care they receive

The pre-admission and admission process informed and oriented clients to the service. Clients attended for a face-to-face assessment before deciding whether to consent to admission. They received a tour of the building from a peer mentor, and had the opportunity to ask the peer mentor about their experiences. Following the initial visit, clients were sent a leaflet about the service that included a personal letter from the peer mentor. This leaflet had been translated into Polish for Polish clients.

Clients were empowered as partners in their care. There was active involvement and participation in care planning and risk assessment. Clients created their own care plans and defined what recovery meant to them. All clients had been offered a copy of their care plan. Clients were encouraged to maintain independence. Staff explained that they did not 'rescue' clients; instead they tried to give clients the skills and confidence to help themselves. Carers and/or families were involved in clients' treatment if the client wanted this. At the end of treatment, each cohort of clients organised their own 'graduation' party. This involved booking entertainment, sending out invitations and providing food and non-alcoholic drinks.

Clients had access to independent advocacy. They were able to give feedback on the service during weekly residents' meetings and/or by completing surveys. We saw that feedback had been acted on (for example, lightbulbs replaced). Clients also contributed directly to their own outcome reports. Previous clients had been involved in designing the service (for example, deciding to restrict access to mobile phones) and recruitment of new staff. Current and recent clients had been given the opportunity to help redesign the service's website. When clients relapsed or left the service and wanted to come back, the clients in the remaining group decided whether or not to agree to this.

We reviewed the feedback that a previous cohort had given after they had completed treatment. Many clients had reflected on how the service had changed their lives. It was

clear from this feedback that staff had shown determination and creativity in the way that they had engaged clients who had negative past experiences of rehabilitation services.

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

Access and discharge

Transforming Choice CIC had been developed to offer a service to alcohol-dependent clients who might be excluded from other residential treatment programmes. It accepted clients who were intoxicated on admission and/or who were receiving drugs for opioid dependence (methadone or buprenorphine). It also accepted clients who had been evicted from hostels or placements because of behavioural issues. The admission criteria were clear, but flexible enough to allow for consideration of individual circumstances. We saw from reports of outcomes for previous cohorts that the service had provided support to vulnerable people including those who were homeless, sex workers, victims of domestic abuse or experiencing mental illness.

The service's treatment programme lasted three months. Clients could not join the programme after it had started. The service accepted four cohorts of 14 clients per year. This meant that there could be a wait of up to three months for a client who was referred and accepted for treatment.

There was no waiting list for the service. The manager explained that there had been occasions when more than 14 clients had been assessed, but it had been found that not all were able to meet the criteria for admission.

Clients set their own goals for recovery early on in the treatment programme. All of the clients we spoke with (who had only been in the service for two weeks) said that they had plans for discharge in place. Staff identified problems with a client's housing at pre-admission stage and supported clients to bid for their own properties with local housing providers. If appropriate housing was not available by the time clients were due to be discharged from the programme, they could rent one of the top floor rooms from Transforming Choice CIC on a short-term basis.

Clients could also be asked to leave treatment if they were not complying with the restrictions. One or two problems were regarded as mistakes, and clients were generally given the opportunity to remain in the service and try again. Staff explained that this was because they tried to avoid reinforcing the cycle of rejection that clients may have experienced in their lives before coming to the service. If clients repeatedly failed to comply then they would be asked to leave. We saw that in one case where this happened, staff took the client to a local hostel. If clients later asked to return, the rest of the client group would decide whether to agree to this.

The facilities promote recovery, comfort, dignity and confidentiality

There was a range of rooms to support treatment and care. There were two separate lounges for clients to use to relax, and private rooms for clients to speak in confidence with staff. There was a group therapy or education room that also served as a dining room. There was a large garden and an undercover smoking area. There were also couches around the building that clients used if they wanted to spend time away from the main group. After the alcohol detoxification was complete, clients had access to their bedrooms during the day. The service was located very close to a large local park, which clients could access with staff during their first four weeks at the service and freely after that.

Clients were able to personalise their bedrooms, for example with photographs and posters. They were able to store valuable personal items in lockers.

Clients chose their own food, which was then bought and cooked by staff. The food was healthy and of good quality. There were two small kitchenettes in the building, which meant that clients could make their own hot drinks, snacks and meals throughout the day.

The structured treatment programme ran Monday to Friday. Staff offered less formal activities at weekends, such as quizzes, bingo, swimming and walks to the park.

Meeting the needs of all clients

The building was partly accessible to wheelchair users. There was a ramp up to the entrance and a fully adapted bedroom on the ground floor. A previous client had been a

wheelchair user. However, it would be difficult for somebody with poor mobility to access all of the rooms; there was an upstairs lounge and a downstairs group room used for education sessions.

The service provided accessible information at pre-admission and admission stage, to help clients know what to expect and how to complain. Key workers spent time in one-to-one sessions explaining which other services were available and how they could be accessed. Information leaflets had been made available in another language (Polish) spoken by clients. The service had acted quickly to obtain the translations, ensuring that they were in place before these clients were admitted. The service could access interpreters from a local homeless and housing charity if needed.

There were no formal arrangements in place for the purchase and storage of food that met dietary requirements of religious and ethnic groups. Staff told us that clients chose their own food, and that they would therefore cater for anyone who had specific needs.

Listening to and learning from concerns and complaints

Information about how to complain was included in clients' induction packs (in Polish as well as English). All of the clients we spoke with knew how to complain, but said they had no reason to do so. There was a 'suggestion box' in the hallway. This was deliberately placed out of view of the closed-circuit television monitoring system, to enable clients to give anonymous feedback.

The service had never received a formal complaint. They had recorded 25 informal complaints between September 2015 and September 2016. All of these had been raised in weekly residents' meetings, and were mainly concerned with maintenance of the building (for example, the washing machine not working, or cleaning tasks not being completed). Action had been taken to resolve these issues.

Are substance misuse services well-led?

Vision and values

Transforming Choice CIC aimed to "offer treatment to everybody no matter their circumstances or situation". They had developed the service to meet the needs of a vulnerable client group. They defined recovery as "the best that you can do" – in other words, something that was achievable and meaningful for each client. This did not always mean complete abstinence. The service's clinical governance document made frequent reference to person-centred care and client involvement. We found lots of evidence of these during our inspection.

Staff shared the organisation's vision and values. It was apparent in the way that staff spoke with and about clients that they believed in the potential for recovery. The most senior manager (the registered manager) was very visible in the service and on first-name terms with all staff. She had a clear passion for her work.

Good governance

There were effective governance structures in place to ensure that staff received mandatory training, supervision and appraisal. There were sufficient staff of the right experience to be able to meet clients' needs. Safeguarding procedures were embedded and followed. The service collected service user feedback and reported incidents. However, there were some areas where effective governance structures were not in place. One to one sessions with the academic psychologist, administration of high-dose vitamin injections, and health and safety checks were not recorded, which meant that the service could not evidence that they had been done.

The service submitted outcomes of treatment to the National Drug Treatment Monitoring System. This enabled them to identify that the proportion of their clients completing treatment (75%) was higher than the average for other alcohol programmes in England (62%). They also provided a three-monthly 'cohort report' for return to their own board and the charitable trusts that funded them. The cohort reports included estimates of the savings for each client on homeless provision and hospital admissions and qualitative information provided by clients themselves about their progress during treatment. Although the cohort reports demonstrated individual outcomes for clients, it was not easy to see what proportion of clients had (for example) achieved sustained recovery or been discharged to their own accommodation. The reports did not include a clear summary that the provider and commissioners could potentially use to compare against previous cohorts and other local and national services.

The service had a board of directors who looked after the day to day running of the business. They met once every

two months to discuss development plans, contracts, policies and procedures and client involvement. There was a board assurance framework and risk register, which covered organisational and operational risks. All staff (including volunteers) were able to add items to the risk register. The clinical governance plan stated that the board reviewed the risk register at bi-monthly meetings. Two of the four sets of minutes provided stated that the risk register had been reviewed, but did not include any detail. The other two sets of minutes did not refer to the risk register.

Staff told us that the board, team and clients had recently updated the business plan and clinical governance document. There was reference to the 2010 registration requirements in the clinical governance document, which were out of date. However, the document overall did provide a framework for future quality improvement, clinical audit and staff development.

Leadership, morale and staff engagement

Staff morale was good. The staff we spoke with said that they loved their job. There had been no cases of bullying or harassment reported. Staff said that they felt able to raise concerns without fear of victimisation. Some staff commented on how caring and supportive the senior managers were, for example managers had telephoned them after a stressful shift to check they were all right. All staff were invited to a meeting after each cohort completed treatment, to reflect on what went well and offer ideas about how to improve next time. Staff told us that they felt involved in service development.

The service had recently organised an externally-facilitated reflective day for staff to help them prepare for the CQC inspection. The minutes of this day showed that staff were proud of the service they offered, but also keen to improve. We saw during our observation of the handover that staff listened to each other's opinions and worked well together.

However, the service received short-term funding from charitable trusts rather than being commissioned by local authorities or clinical commissioning groups. Although local authorities had spot purchased individual placements. It was clear from minutes of board and team meetings that senior staff were liaising with other organisations and thinking creatively about how to continue providing the service. The registered manager had worked hard to ensure that staff were fully informed and engaged with the process.

Commitment to quality improvement and innovation

Transforming Choice CIC provided an innovative service to vulnerable clients. Informal feedback from clients suggested that the alcohol detoxification and residential programme was an effective and positive experience. The provider used feedback from staff and clients to continually develop and improve the service. Ex-clients were involved in writing leaflets, revising the residential activity schedule and designing the website.

However, the service did not collect standardised, quantitative data. This meant that outcomes could not be easily summarised or compared with those of other services.

Outstanding practice and areas for improvement

Outstanding practice

People were truly respected and valued as individuals and were empowered as partners in their care. There was a strong, visible person-centred culture. The service had been designed to overcome obstacles in delivering care to vulnerable people. It received consistently positive feedback from its clients.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all administration of medication and individual sessions with clients are recorded.

Action the provider SHOULD take to improve

- The provider should ensure risk management plans are completed for all clients.
- The provider should ensure that environmental health and safety checks are recorded.
- The provider should ensure that their clinical governance document refers to current requirements and legislation.

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 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Records of the care and treatment provided did not include evidence of the administration of medication (high dose vitamin injections) or of individual sessions with the academic psychologist. **This was a breach of Regulation 17(1)(2)(c)**