

Manchester Mental Health and Social Care Trust

Substance misuse services

Quality Report

Manchester Mental Health and Social Care Trust
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
TAE02	Laureate House	The Brian Hore Unit	M20 2LR
TAE02	Laureate House	The Community Alcohol Team	M12 4LL

This report describes our judgement of the quality of care provided within this core service by Manchester Mental Health and Social Care Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Manchester Mental Health and Social Care Trust and these are brought together to inform our overall judgement of Manchester Mental Health and Social Care Trust.

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We found that Manchester Mental Health and Social Care Trust provided substance misuse services to people experiencing issues with alcohol that were caring, effective and responsive. This was because:

- Environments were welcoming with kind and respectful staff.
- People were comprehensively assessed in a timely manner.
- Staff attempted to meet the diverse needs of people using the service.
- Staff were encouraged to develop to meet the needs of people using the service.
- Staff were well supported.
- People using the service were involved in decisions about the service.

But we also found:

- Cover arrangements for sickness were ineffective.
- Security arrangements did not protect the safety of people using the service or staff.
- Staff did not periodically review risks of all people using the service.
- Care plans were not always individual or regularly reviewed.
- Staff were unable to track individual prescription numbers from a central record.
- There was a disconnect between the service and the overall trust.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

We found that:

- Clinical staff had a good knowledge of safeguarding.
- Staff were able to access information on children through social workers attached to the community alcohol team.
- Staff understood their responsibilities in reporting incidents.
- Staff were open and transparent when things went wrong.

However:

- Security measures at the Brian Hore unit did not protect staff and people using the service.
- Cover arrangements for sickness at the Brian Hore unit did not always ensure safety.
- Some people using the service did not have their risks periodically reviewed.
- Staff were unable to track individual prescription numbers effectively.

Are services effective?

We found that:

- Staff completed comprehensive assessments in a timely manner.
- Staff demonstrated understanding and compliance with NICE guidance.
- Clinical staff developed and conducted clinical audits which resulted in action plans to improve their practice.
- Staff were encouraged and supported to develop their knowledge.
- The service had good relationships with GPs.

However:

- Care plans were not up to date, personalised, holistic or recovery focused in the Brian Hore unit.
- Staff from the community alcohol team stored paper based information inconsistently.
- Staff were not supervised in line with the trust's supervision policy, although they were well supported in their roles.

Are services caring?

We found that:

- Staff were kind and respectful to people using the service.

Summary of findings

- Service users were involved in the development of a support leaflet for family and friends.
- There were weekly user consultation sessions and a quarterly user group where people using the service could be involved in developments and decisions.

However:

- Staff did not encourage people to develop independence from the Brian Hore unit.

Are services responsive to people's needs?

We found that:

- GPs were able to book appointments directly for people to be seen by the community alcohol team.
- Staff at the community alcohol team planned a person's discharge from the start of their treatment.
- The facilities were welcoming.
- Staff took proactive steps to ensure homeless people were able to access support.
- People using the service knew how to make a complaint if necessary.

Are services well-led?

We found that:

- Staff felt supported within the service.
- Staff were encouraged to develop by managers at service level.

However:

- Staff did not feel that the service was understood by senior management.
- Trust governance systems were not effective or appropriate to the service. There were systems in place to ensure that staff were competent staff but this was service led.

Summary of findings

Background to the service

Manchester Mental Health and Social Care Trust are commissioned to support people experiencing or having experienced problems due to their alcohol use.

The Brian Hore Unit offers abstinence based treatment for adults with alcohol problems. This includes those with a dual diagnosis (people with both substance abuse and mental health issues), who live in Manchester. Services available at the unit include a drop in centre, daily support groups, individual counselling, daily detoxification and psychiatric treatment.

The community alcohol team provides support for anyone over the age of 16 concerned about their drinking. The service operates out of community settings mainly in 39 GP surgeries. Treatment packages include co-ordinated detoxification in a community or access to residential settings, key work sessions and assistance with other areas in people's lifestyles impacting on their drinking.

Our inspection team

Our inspection team was led by:

Chair: Steve Shrubbs, Chief Executive Officer, West London Mental Health NHS Trust

Team Leader: Brian Burke, Care Quality Commission

Head of Inspection: Nicholas Smith, Care Quality Commission

The team that inspected the core service included a CQC inspector and a variety of specialists:

- One experts by experience
- A specialist social worker in substance misuse
- One qualified nurses
- Student nurse

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

How we carried out this inspection

To get to the heart of the experiences of people who use, 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 visiting, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew. We attended the trust's annual members meeting and invited patients and members of

the public to meet with us. We also arranged a focus group prior to the inspection, facilitated by a voluntary organisation. We carried out announced visits to the service on 24 and 25 March 2015.

During the visit we met and interviewed 19 members of staff who worked within the service, including a manager, a consultant, key workers and volunteers.

We met with 13 people who were using the services who shared their views and experiences of the services we visited.

Summary of findings

We observed how people were being cared for and reviewed care or treatment records of 19 people. We looked at a range of records including clinical and management records.

We observed a multi-disciplinary meeting and a daily support group.

What people who use the provider's services say

We spoke with 13 people who were using the service. Comments were all positive describing staff as supportive. People reported that they felt safe at the service and felt they were treated with dignity and respect.

Areas for improvement

Action the provider **MUST** or **SHOULD** take to improve

Actions the provider should take:

- The trust should increase the security and accountability for all people entering the Brian Hore unit.
- The trust should ensure staffing levels are adequate to accommodate unexpected sickness or ensure contingency plans are developed so prevent lone working.
- The trust should ensure all groups of people using the service have up to date recorded risk assessments and management plans.
- The trust should ensure individual prescription numbers are recorded in a central location to enable an effective audit trail.
- The trust should ensure all groups of people using the service have individual, up to date and recovery focused care plans.

Manchester Mental Health and Social Care Trust

Substance misuse services

Detailed findings

Name of service (e.g. ward/unit/team)**Name of CQC registered location**

The Brian Hore Unit

Laureate House

The Community Alcohol Team

Laureate House

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

We found that :

- Clinical staff had a good knowledge of safeguarding.
- Staff were able to access information on children through social workers attached to the community alcohol team.
- Staff understood their responsibilities in reporting incidents.
- Staff were open and transparent when things went wrong.

However:

- Security measures at the Brian Hore unit did not protect staff and people using the service.
- Cover arrangements for sickness at the Brian Hore unit did not always ensure safety.
- There were ineffective tools in place to ensure risks were reviewed for some people using services.
- Staff could not effectively track individual prescription numbers.

Measures used to ensure security and people's safety at the Brian Hore unit were not effective. The unit was an open building with all rooms located from one single corridor. The reception was located at one end of the corridor. There were no measures in place to prevent a person entering the building and accessing any unlocked room off the corridor. This included clinic rooms, offices and group rooms. However, medications were not accessible as they were not dispensed from the service. On the day of our inspection we were not asked to sign into the building or show any form of identification. People using the service were recorded if they attended groups but not for using the day room. In the event of an emergency evacuation, there were therefore no logs to ensure everyone's safe exit.

Furnishings in the Brian Hore unit were in the process of being updated to wipe clean materials to control the spread of infections. We observed posters on effective hand washing techniques and non-alcohol based hand gels were available throughout.

Medical equipment was available and checked routinely.

Safe staffing

Staff at the Brian Hore unit operated a two shift system covering the hours between 9am till 8pm. The service was 30% understaffed due to maternity leave and an unfilled position. These shifts were covered by two familiar bank workers. The service planned for a minimum of two staff at all times. However, staffing levels were not always safe when a staff member phoned in sick. We were told of an incident where a member of staff had called in sick for a shift covering the evening. The remaining member of staff continued with the group session as planned but locked the service doors. Whilst staffed alone with people using the service, a distressed member of the public attempted to access the building. This resulted in security staff from the nearby hospital attending to enable the safe departure for people in the group and the staff member. One lone worker may not always be in a position to alert security for assistance. Staff told us that the normal procedure would be for staff to lock up the building in pairs.

The community alcohol team had no vacancies and two workers on long term sickness. Staff were aware of the lone worker's policy and used the mobile phone application to

Our findings

Safe environment

The team locations we visited were clean, tidy and well maintained.

People accessing the services signed a behavioural code of conduct agreement on commencement. There were posters in the reception of the Brian Hore unit highlighting the consequences of unacceptable behaviour. All the rooms in the unit had panic alarms that were linked to the adjacent acute hospital. Staff had also implemented a yellow and red card system which could result in exclusion from the day centre. Staff from the community alcohol team visited various community settings. Staff told us they felt supported from teams within these venues. Additionally, these staff used a mobile phone application which tracked their location and alerted police in emergency.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

protect their safety. Staff told us that the staffing numbers were not sufficient to meet the needs of people using the service. This resulted in longer waiting times for people to access treatment.

Assessing and managing risk to patients and staff

People using services at the Brian Hore unit were risk assessed on their induction. Effective management plans were then implemented for these risks. If their treatment involved prescribing, had mental health issues or they were initially assessed as high risk, their treatment would involve key work sessions where risks would be reviewed. Staff continued to effectively review and manage risks for this group of people.

However, this was not the case for people who did not receive key work sessions and used the service only for support groups or the day centre. There were no tools or processes to ensure that risks were reviewed periodically. Risk assessments were therefore historic and did not reflect or identify a person's changing circumstances. We observed the records of a person using the service from 2010. At the time, this risk assessment was paper based and could not be located. There were no details of any further assessment of risks on the electronic system. This is therefore reliant of staff knowing individuals' risks without records. New workers may then be unaware of potential risks which need consideration. However, staff did effectively manage risks which had been identified through informal methods. People using the Brian Hore unit, mostly used the service for long term support to remain abstinent from alcohol. The informal nature of the service enabled them to do this without unnecessary constraints to engage with appointments.

The community alcohol team risk assessed people as part of the comprehensive assessment. Generally, plans to manage identified risks were then embedded into narrative case notes.

Staff from both locations used effective safety plans if it was identified that self-harm was a concern.

Staff ensured that those people waiting to be seen for their first appointment, received advice for actions to take if their circumstances worsened.

Clinical staff demonstrated a good understanding of safeguarding procedures. They were all trained up to at least level two in safeguarding. However, administration staff were only required to complete the trust's e-learning module although they were often the first point of contact for people using the service. Both services were able to seek information on children through the social workers attached to the community alcohol team.

Medications were stored in line with National Institute of Health and Care Excellence (NICE) guidelines. Prescription books were stored in locked cupboards with records of who the prescription books are issued to. The trust prescriptions had three copies; one for the person using the service, one for the pharmacy and one for records. The copy for records was stored in the person's individual file. Effective medicines management recommends these be stored in a central location to enable a thorough audit trail.

Reporting incidents and learning from when things go wrong

Staff told us that they knew what constituted an incident and how to report it. Incidents were discussed in weekly clinical governance meetings. More serious incidents had immediate debriefs prior to the meeting. We saw action plans from serious untoward incidents and lessons learnt were shared trust wide on the intranet.

We were informed of an incident where a letter to a person using the service was manually posted through the wrong person's door. Staff were transparent to the person and explained the error with apologies.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

We found that:

- Staff completed comprehensive assessments in a timely manner.
- Staff demonstrated understanding and compliance with NICE guidance.
- Clinical staff developed and conducted clinical audits which resulted in action plans to improve their practice.
- Staff were encouraged and supported to develop their knowledge.
- Good relationships with GPs.

However:

- Care plans were not up to date, personalised, holistic or recovery focused in the Brian Hore unit.
- Staff from the community alcohol team stored paper based information inconsistently.
- Staff were not supervised in line with the trust's supervision policy although they were well supported in their roles.

(AUDIT) or the severity of alcohol dependence questionnaire (SADQ). These are screening tools to determine the severity of a individual's alcohol use. A person was then offered four structured sessions if thier severity was scored low. For others with greater need, staff then completed a comprehensive assessment; gathering full information. This cohort of people then received case management which included individual, holistic and up to date care plans.

All current information gathered for the Brian Hore unit was stored on the trust's database system AMIGOS.

Information for people using the community alcohol team was stored on the electronic system which was owned by previous commissioners. This system was called LORENZO. Additionally, information was also stored on the GP's electronic system called EMIS. This enabled the GP to have access to the notes and vice versa. The service also stored notes in paper based systems. We found the paper notes were stored inconsistently dependent on the worker and the location the person was seen.

Best practice in treatment and care

Staff prescribed medications in line with the NICE guidance for alcohol use disorders, diagnosis and clinical management. The trust's chief pharmacist cascaded new guidance and changes to the service. This was then discussed in team meetings to ensure best practice is delivered.

Staff assessed people for their suitability for assisted withdrawal from alcohol. This could take place in the community. Alternatively, the service would submit a case for residential funding. At the time of our visit, there were no community detoxifications occurring. We did however observe past records which showed interventions were compliant with NICE guidance.

The service used evidenced based interventions either through key work sessions or people accessing groups at the Brian Hore unit. People awaiting detoxification attended motivational groups. These groups were available to people receiving treatment from either service. One worker had been trained in the international treatment effectiveness programme.

Weekly self management and recovery training groups and AA meeting were accessible to people from both services at the Brian Hore unit.

Our findings

Assessment of needs and planning of care

People received a comprehensive assessment following referral. Staff gathered information on the person's alcohol and substance misuse, physical health, mental health, legal status, social circumstances, information on children and individual goals.

Care plans for people using the Brian Hore unit were not personalised or holistic. Care plans used were standardised with a menu of options. These options included attendance at groups, referral to psychiatry and agreement to confidentiality. If a person did not attend key work sessions or clinical appointments, these care plans were not reviewed. This was not the case for people receiving prescribing intervention or for people with high risks due to their mental health. Staff completed care plans with greater detail which were periodically reviewed.

Staff from the community alcohol team assessed people which determined the level of care they received. This was done using the alcohol use disorders identification test

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Staff considered physical health needs as part of the assessment process. For people who were seen at their own GP surgeries this was recorded onto the electronic system for the GP to see and action. For those people seen at the Brian Hore unit, the doctor sent referrals to GPs. For example, recommendation for blood borne virus testing. We saw malnutrition universal screening tools in records showing us that staff had recognised wider health issues relating to alcohol use.

Staff used alcohol outcome stars as a visual picture to monitor progress in a person's treatment journey. This tool tracks changes in various areas of a person's life. For example, emotional, offending, social networks and meaningful use of time.

Changes and progress of people using the service were also measured using treatment outcome profiles (TOPs). TOPs are monitoring instruments developed by the National Treatment Agency to be used at the start of treatment and in care plan reviews and reported through the National Drug Treatment Monitoring System (NDTMS). At the time of our inspection NDTMS had been off line for some months. Public Health England hold the responsibility for gathering these statistics and through this providing data locally and nationally on those people successfully leaving treatment for drug and alcohol misuse. This information was therefore unavailable to enable us to consider how the services performed nationally.

Clinical staff participated in audits. The senior house officer had recently completed an audit on the prescribing of Antabuse. The audit concluded that prescribing was compliant with NICE guidance and showed an action plan to improve record keeping and required staff to further encourage people to engage in psychosocial interventions.

Skilled Staff to deliver care

The trust employed a range of disciplines to support people using the service. This included a psychiatrist, doctors, a manager, a deputy manager, nursing staff, support workers and administrators. These were supported by volunteers.

Staff were compliant in the trust mandatory training, this included resuscitation and breakaway techniques. We were told that training is encouraged within the service however the organisation was not familiar with their specific training needs. The manager therefore sought more relevant training for staff. For example, the team had recently

received personality disorder training and had previously invited medical representatives to increase awareness in medications. Staff were also due to attend a free conference about embedding research into practice for substance misuse.

Staff were encouraged to further develop their knowledge in specialist areas. There was one worker trained in cognitive behavioural therapy and another worker who specialised in research. The teams had themed learning days where learning could be shared.

Training was not mandatory in psychosocial interventions. NICE recommend that a psychosocial element is involved in treatment packages. Staff had however generally received this training through previous roles or additionally requested training enabling them to meet the needs of people using the service.

Staff mainly told us they felt supported in their roles and that they received supervision. However, the service was not monitored by the trust on their compliance with the trust's supervision policy. Staff supervision was still occurring but in line with historical policies. This entailed a staff member bringing their own agenda to their supervision and recording this for their own purposes. We were therefore unable to obtain any supervision records. Volunteers also received monthly supervision and the consultant carried out supervisions for other clinical staff. Staff informed us that their supervisions included staff issues, caseload and risk management. Bank staff had no supervision mechanism although they were seen as regular continuous cover.

All staff had up to date personal development plans which they considered well structured with clear objectives.

Staff attended a weekly clinical governance meeting which discussed service improvements, NICE guidance, good practice, specialisms and peer supervision.

Multi-disciplinary and inter-agency team work

There was a weekly clinical review meeting. This was attended by the consultant, doctor, nurse on duty, service manager and when needed, the social worker attached to the community alcohol team. The meeting reviewed patients that were receiving case management care. This meeting was also used as to discuss people who are between the community alcohol team and the Brian Hore unit.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Records demonstrated good partnerships with people's GPs. We saw detailed notes from the consultant and doctors for people in their care. A GP told us that communication was very easy and extremely helpful.

The community alcohol team delivered a clinic from a housing office and were able to use this agency to address benefits for housing. They also received referrals from a criminal justice programme aimed at addressing the multiple needs of women as an alternative to low custodial sentences. This programme called 'women matter' consists of a multi-agency team including probation, women's aid, housing, mental health services to develop a package of care.

The service was currently working with midwives to improve treatment for pregnant women.

Individual complex cases were referred to the dual diagnosis team at Manchester Royal Infirmary. There was interaction with Manchester's drug service on a case by case basis if a person was also abusing drugs.

The Brian Hore unit had information on display for access to the citizens advice bureau, gambling support and routes for education.

Good practice in applying the MCA

Staff demonstrated a good understanding of the MCA. They were confident that they could access advice from the intranet and the consultant whenever needed.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary of findings

We found that:

- Staff were kind and respectful to people using the service.
- Service users were involved in the development of a support leaflet for family and friends.
- There were weekly user consultation sessions and a quarterly user group where people using the service could be involved in developments and decisions.

However:

- Staff did not encourage people to develop independence from the Brian Hore unit.

Our findings

Kindness, dignity, respect and compassion

Staff treated people who use the service with respect, kindness and dignity. We observed people who used the service to be relaxed in the environments we visited. We observed people being greeted with politeness and warmth.

Staff clearly informed people using the service where their information would be passed. This included the National Drug Treatment Monitoring Service, GPs, health visitors and school nurses.

People's dignity was considered with clinical rooms having curtains around the medical couches. People's confidentiality was maintained with confidential waste bins and locked files.

Although not everyone using the service had key work sessions, people told us that the staff were approachable and always there to help.

We observed staff keeping people informed as to waiting times for appointments in a friendly manner.

The involvement of people in the care they receive

People who were receiving case management told us they felt involved in their care plans. We observed people's participation in key work sessions. However, care plans were not clearly identifiable in all records.

Not all people using the Brian Hore unit received individual key work sessions and care planning. There was a welcoming atmosphere with arranged activities including social nights, an allotment project, day trips, snooker in the day room, access to a play station and knitting groups. These were accessible to all people using the service. Therefore, for some people there was little evidence of encouragement from staff to gain independence from using the facilities and accessing their on-going support from the wider community.

Family members were able to attend assessments. However, they were not permitted to access activities in the Brian Hore unit other than the reception area. Staff signposted family members to the Manchester carer group. People using the service had helped develop a leaflet for family and friends to use for support and advice. This leaflet was displayed in the reception areas used by the service.

People using the Brian Hore unit had a weekly consultation with staff which enabled them to communicate any concerns. For example, feedback from groups. There was a quarterly service user group. This meeting allowed an opportunity for people to identify ideas for improvement as an example. People attending this meeting agreed how funds gained from refreshments could be used. Past activities funded in this way included a trip to a theme park and a wide screen television for people to watch the world cup.

The service conducted an annual service user survey. The last survey contained positive feedback. Survey findings were fed back to people using the service.

We observed clinical appointments where medications and health impacts were clearly explained.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary of findings

We found that:

- GP's were able to book appointments directly for people to be seen by the community alcohol team.
- Staff at the community alcohol team planned a person's discharge from the start of their treatment.
- The facilities were welcoming.
- Staff took proactive steps to ensure homeless people were able to access support.
- People using the service knew how to make a complaint if necessary.

However:

- The Brian Hore unit did not encourage independence or plan discharge from the service.

Our findings

Access, discharge and transfer

The service accepted referrals from all sources. This included self-referral, GPs, criminal justice, social services and other health professionals. Waiting times at the Brian Hore unit were generally within two weeks. The community alcohol team saw most people for assessment within three to four weeks. This was slightly over their 15 day target. GPs were able to book their patients directly into their electronic appointment system for the community alcohol team. We were told by a GP that the service saw someone within a week if the GP felt it was urgent.

The service did not exclude any referrals. The initial assessment determined a person's needs and their suitability to different levels of treatment.

Staff who assessed people referred to the community alcohol team started to plan for their discharge at the time that treatment commenced. This could be after a period of brief interventions, a community or residential detoxification, transfer to the Brian Hore unit or referred to external agencies for further on going holistic support. The service offered a text based intervention service to people who were not transferring to further organisations to ensure a gradual decrease in support into independence.

The Brian Hore unit did not plan a person's discharge and told us treatment was open ended. They told us that

people who had remained abstinent from alcohol for long periods of time went on to facilitate groups. We spoke with one person who had been using the service for 20 years as an aftercare facility. Records showed us people remained with the service for long periods of time after their drinking had ceased. We did not see evidence from staff encouraging people to seek alternative community based sources to sustain their recovery. The unit did not encourage independence and discharge allowing people to continue accessing the service as on-going support to maintain their alcohol free lifestyle. At the time of our inspection, this had no impact of capacity and future referrals.

Staff made attempts to engage people who were missing appointment if they had been receiving key work support. This was done through GP contact, phone calls and letters. The Brian Hore unit carried out three monthly checks on people who were recorded as actively using the service. These checks were used to see if people were still attending the unit for groups or to use the day room. Staff discharged them if they no longer accessed the service.

Staff kept people informed when waiting for their appointments. People who used the service told us they had not experienced cancelled groups or appointments.

The facilities promote recovery, dignity and confidentiality

The community locations we visited used by the community alcohol team were all welcoming and comfortable environments.

The Brian Hore unit had two group rooms, three clinic rooms, two counselling rooms and a day room. All the rooms had well maintained furnishings. The day room was very welcoming and included a pool table and refreshment area. Art work from people using the service was displayed around the building. There was a resource room which contained a large selection of leaflets, posters and information including volunteering, health and well-being and advocacy. People used the room to share reading books and there was also a television and playstation in the room for use.

Meeting the needs of all people who use the service

The staff respected people's diversity and human rights. Attempts were made to meet individual needs including cultural, language and physical needs. Interpreters were

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

available to staff if required. There were specific groups for men and for women. Access was available to people using wheelchairs. We saw evidence of support for older people. For example, staff worked with Age Concern to enable a 71 year old man to receive support for his alcohol use.

The community alcohol team recognised that some people with housing problems found it difficult to meet set appointment times at different locations. They took a proactive approach by delivering a drop in clinic from a GP surgery which was used by people who were homeless. This surgery was also used by other services reducing the need for people to attend many different places. This was particularly useful for homeless alcohol users as they

mostly also have issues with other substances. The Manchester service for drug users also used this location enabling this group of people to receive support without appointments and from one accessible location.

Listening to and learning from concerns and complaints

People using the service told us they were confident that they could speak to someone to complain if they wanted to. We saw posters in the reception area of the Brian Hore unit about making a complaint and also about how to offer suggestions or compliments. Staff told us that the service had not received any complaints in over a year. They told us they listened to concerns from people with the aim of an informal resolve.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

We found that:

- Staff felt supported within the service.
- Staff were encouraged to develop by management at service level.

However:

- Staff did not feel that the service was understood by senior management.
- Trust governance systems were not effective or appropriate to the service. There were systems in place to ensure competent staff but this was service led.

Our findings

Vision and values

Staff were made aware of the trust's vision and values through a daily intranet message and from blogs from the chief executive. Paper copies of these were attached to their most recent payslips. We also saw a guiding principles poster displayed in the reception area of the Brian Hore unit.

Generally, staff were not familiar with the senior leadership team from the trust. They felt detached from the trust and that senior managers did not understand the service. Some staff recalled a visit from the leadership team regarding the staff survey.

Good governance

Local systems were in place which ensured staff were well supported and received adequate training to do their job. Staff did learn from incidents, complaints, audits and service user feedback. However, this was mainly led at service level with trust governance systems being ineffective or inappropriate to the alcohol services. For example, audits were developed by management appropriate to alcohol services.

Leadership, morale and staff engagement

We saw that the community alcohol team and the Brian Hore unit were well led. The manager was visible and accessible. Staff appeared enthusiastic and informed us they were well supported by the local managers and enjoyed their jobs. Staff were aware of the whistleblowing process but some said they would be cautious about escalating concerns higher in the trust. Staff told us that at service level their well-being was cared about, they felt respected and were encouraged to develop.