Phoenix Futures Wirral Residential Service

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated Phoenix Futures Wirral Residential Service as good because:

- The service had up to date health and safety assessments. the environment was clean, comfortable and well maintained. We saw staff adhering to infection control principles, with hand-gel dispensers being used around the building and stringent hygiene checks in the kitchens.
- Staffing were trained and there were sufficient numbers that met the needs of service users.
- Risk assessments were comprehensive and up to date. There were plans in place for patients who decided to leave the programme before its completion. Staff administered and managed medication effectively. All staff knew how to report incidents, and understood the duty of candour.
- Care records were comprehensive, holistic, and completed in a timely manner. All relevant information pertaining to the patient and the treatment programme was outlined in the records, and included input from the patient. The service was following best practice and national guidance with relation to treatment. Care records were up to date and had been amended according to events involving the patient. All staff had completed mandatory training, were up to date, and records were maintained in personnel files. Multi-disciplinary team approach was evident, with input from care managers external to the service. Staff were trained in the Mental Capacity Act.
- We saw good interaction between staff and patients at the service, with respect being shown to all parties. Patients felt comfortable with staff at the service, and felt they could talk to them as several staff members were former patients in the treatment programme. Patients told us they felt supported and safe at the service. Care records showed that patients could understand and knew what treatment they were getting and why. We saw evidence of family involvement, and a new family visiting room had been built onto the main building. Patient forums and survey results indicated that patients were very happy with the service.
- The referral and assessment process for the service was comprehensive. Patients who entered the service and found that the treatment was not suitable were transferred to other services using pathways in place. Discharge planning started on admission to the service, with plans in place for possible early leaving of the programme. Patients were encouraged to contact families and try to integrate them into their treatment programme. There were employment and education opportunities for patients at the service, with a good success rate. Several staff at the service were former patients, and had gone on to attain good qualifications in health and social services. Equality and diversity was stressed at the service. There had been only one formal complaint in the 12-month period prior to the inspection, and 15 formal compliments had been received in the same period.
- Managers at the service provided key leadership, with the skills, knowledge and experience required. There was a clear definition of recovery within the model followed at the service, and staff were aware of it. Staff could input into the organisational strategy for the service. Staff said they felt valued and supported, they were happy working in the service. Staff appraisals indicated career development and consideration of training courses that might be helpful. Leadership training was available to all staff at the service. Key performance indicators were used to identify and promote good practice, and to identify aspects that required action. Staff were recognised at an annual awards ceremony.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services	Good	

Summary of findings

Contents

Good

Phoenix Futures Wirral Residential Service

Services we looked at

Substance misuse services

Summary of this inspection

Background to Phoenix Futures Wirral Residential Service

Phoenix Futures Wirral Residential Service is part of a not-for-profit organisation; a charity and housing association. This residential service offers drug and alcohol free residential rehabilitation to those with substance misuse problems, which includes limited detoxification, but which is primarily rehabilitation. The service offers a medically monitored treatment model, which was deemed more therapeutic than a medically managed treatment model, whilst still providing a robust level of clinical oversight. Patients stay in a large suburban house in the Wirral, close to Liverpool. A team of drug and alcohol workers provide personalised support through one-to-ones, group and alternative therapies. Residents spend their first few weeks in a separate wing called 'welcome house' while they settle into their new surroundings and then move into the main house for the rest of the programme, which lasts between three and six months. Residents are responsible for the day-to-day running of the house and support each other throughout the programme with more senior residents becoming 'buddies' for new residents. After completing treatment at the residential service, residents are supported to move onto supported housing services or their own accommodation. The service could take up to 35 patients. At the time of inspection there were 31 patients staying at the service.

The service has a registered manager; however, at the time of the inspection the registered manager was not available, and an acting registered manager was in place, as confirmed by notification to the Care Quality Commission.

The service is registered for the activity of accommodation for persons who require treatment for substance misuse.

The service was last inspected on 8 August 2016, the report being published on 14 November 2016. The service has been inspected on three other occasions, when substance misuse services were not given a rating by the CQC.

Our inspection team

The team that inspected the service comprised three inspectors.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

Summary of this inspection

- toured the service, looked at the quality of the service environment and observed how staff were caring for patients
- spoke with eight patients who were using the service
- spoke with the acting registered manager
- spoke with five other staff members including therapeutic workers and two senior managers
- looked at seven care and treatment records of patients
- looked at two personnel files
- carried out a specific check of medication management and reviewed 31 medication records, and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with patients who used the service, and were told only positive points about the service. All patients we spoke to were happy with the service and felt that it met their needs. Patients felt safe and described how the programme allowed them to progress through their treatment with positive results.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- The service had a full, up to date health and safety environment check history.
- Guidance regarding mixed sex accommodation was followed at the service.
- The service environment was clean, well maintained, and well furnished.
- Staffing was appropriate for the service, with protocols in place to manage any absence.
- Physical health monitoring was taking place for all patients at the service.
- Medication management was well documented and followed policy.
- Incidents were reported and dealt with, lessons learned were shared.

Are services effective?

Good

We rated effective as good because:

- Care records were comprehensive, holistic and up to date.
- The service followed best practice and relevant guidance for the treatment of substance misuse.
- Staff at the service had all completed mandatory training, with additional training available to all staff.
- The multi-disciplinary team worked well, with input from external stakeholders and partners.
- Supervision and appraisals were taking place regularly, and were recorded in personnel files.
- Mental Capacity Act training was given to staff, and the importance of capacity and consent was evident in care records.
- The service employed volunteers who received an induction and access to training.

Are services caring?

Good

We rated caring as good because:

- Patients were all positive about their experience at the service.
- We saw good interaction between staff and patients during the inspection.
- Patients told us they felt supported.
- Care and treatment was clearly explained to patients.

Summary of this inspection

- Each patient had a recovery plan in place with clear pathways to other agencies.
- Engagement at the service was encouraged as part of the treatment programme.
- Families and carers could give input into the service.

Are services responsive?

Good

We rated responsive as good because:

- The referral and assessment process was thorough, and patients were fully informed.
- Discharge planning started immediately on admission to the service.
- There was an early leavers plan in place to support patients who did not want to stay for the full treatment programme.
- Patients were supported to access suitable accommodation as part of discharge planning, and after considering all available options, their stay could be extended to ensure safe discharge from the service,
- Patient pets were welcome at the service, with kennels and hutches in place for patients to house their pets.
- There were work and education opportunities for patients at the service.
- Equality and diversity were promoted at the service.
- Patients knew how to complain. There was only one formal complaint at the service, and 15 written compliments.

Are services well-led?

Good

We rated well-led as good because:

- The service was very well led at service level.
- There was a commitment towards continual improvement.
- Leadership training was available to all staff at the service.
- The service was very responsive to feedback from patients, staff and external agencies.
- The provider recognised staff success with an annual awards programme.
- Governance policies were in place and were followed.
- Key performance indicators were used to inform and guide the service to improve.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

The service had a Mental Capacity Act and Deprivation of Liberty Safeguards standard operating procedure in place. The provider did not admit patients who lacked capacity to consent to treatment, and felt staff should be aware of the Deprivation of Liberty Safeguards although patients detained under Deprivation of Liberty Safeguards would not be considered for admission. Staff were trained in the Mental Capacity Act, and this was reflected in interviews with staff. Care records showed that capacity was considered, and that on admission patients were assessed for capacity as a part of admission criteria. Two advocacy services were available to patients.

Overview of ratings

Our ratings for this location are:

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

Good

Substance misuse services

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

Are substance misuse services safe?

Good

Safe and clean environment

The service had up to date environmental health and safety assessments. The operational risk assessment included gas check certificates, fire check certificates, deep clean of kitchens certificate and de-lint of washing machines. The assessment had been carried out in December 2018, and was due for review in March 2019. Fire safety checks included a list of all staff who were trained as fire marshals. A fire risk assessment (internal) had been carried out in August 2018, with dates and times of full fire drills and evacuations. Staff completed two fire drills and evacuations in January 2019. The external fire risk assessment was due to be renewed in July 2019. Emergency lighting check was due for renewal in July 2019, and there was evidence of internal fortnightly checks on the emergency lighting at the service. The service had a colour coordinated health and safety structure which defined the health and safety expertise and responsibilities of staff. Fire-fighting equipment was checked weekly, and this was logged, as were fire doors and windows at the service. There were certificates for safe removal of clinical waste and removal of used fat from the kitchens (which was taken for recycling). There was a ligature risk assessment held at the service.

The service did not utilise personal alarms or call buttons, other than in the disabled access bathrooms. After patients went to bed, alarms were set on exit and access points to the building with a warning system set up in the bedroom of the staff member who stayed at the service during the night, thereby alerting the staff member and not disturbing the patients should someone try to enter or leave the building. There was an emergency on-call system that utilised an on-call manager for advice and direction out of normal working hours.

Mixed sex accommodation guidance was in place at the service, requiring that patients did not share sleeping accommodation, bathroom and toilet facilities with patients of the opposite sex, and that patients did not have to pass through opposite sex accommodation to reach their own toilets and bathrooms. Living areas were separated, with different landings for males and females, with single sex routes available. There was a lounge assigned to females only. The service had a check list for action regarding breaches of their same sex accommodation guidance, but there was no evidence that any breaches had occurred in the 12-month period prior to the inspection.

The service location was very clean. Although the house was an old structure it had been well maintained, with additional outbuildings added over time. Furniture was comfortable and in good repair. During the inspection we noted hand-gel dispensers in place at the location and saw staff and patients using them throughout the day. Clinical waste, such as sharps boxes, were dated and recorded appropriately, and were safely removed from the service by a clinical waste removal company. Patients working in the kitchen were seen to be washing their hands before and after dealing with food (patients all had training and certificates in kitchen and food hygiene).

The service had a small medication administration/storage room. There was a very large walk-in safe that also held the controlled drug cupboard. The medicine management policy listed the types of controlled drugs that could be

stored at the service, as well as clearly outlined guidance as to storage and administration. A whiteboard (closed) on the wall held patient medication details, relating to timings during the day when a patient was scheduled to have medication administered. Fridge temperatures had been recorded, but the results showed that staff were having difficulty getting an accurate reading, though all readings were within the acceptable temperature range. We raised this with managers at the service, and the day after the inspection a new refrigerator was delivered with an easy read thermometer, designed specifically for the storage of medication. We checked paperwork that showed clinical waste had recently been correctly removed from the service, as well as old medication that had been returned to the pharmacy. The sharps box in the room was dated. The room was clean and functional. The service also had a clinical examination room with an examination couch and equipment that was calibrated and dated clearly. There was access to full emergency equipment and emergency supplies of naloxone, in keeping with national guidance on detoxification. The flooring in the room met expected clinic room standards with flooring that allowed full access when cleaning, and the sink did not have an overflow.

Safe staffing

The service had 13 substantive staff working at the service, this included one registered mental health nurse and therapeutic staff. The service also had two volunteer workers, former patients of the service. We were told that the service calculated its staffing levels on a one staff member to eight patient basis. Bank staff were known as sessional staff, consisting of three staff but including the use of staff from other locations run by the provider. We were told that sessional staff were not used very often. In the three months leading up to the inspection, the service utilised sessional staff on 14, 16 and 29 occasions, the 29 occasions over the Christmas period: the service ran on almost 150 shifts a month. Sessional staff were also used to provide more cover during external activities away from the service. Rotas were checked and showed a consistent level of staffing at the service. Data provided by the service showed that the sickness level was at 2.9%, and reflected long term sickness at the service. There were no vacancies for staff at the service.

All staff at the service had undergone induction into the service, and this was reflected in their personnel files. This included sessional staff, who had also undergone disability and barring service checks. Disclosure and Barring Service checks had been completed on all staff at the service.

Staff received mandatory training and each staff member had personal training planner. This included mandatory/ statutory training, specialist training, organisational training, and personal development training. Each personnel file for staff contained an up to date copy of the training planner completed by staff, including certificates as proof of completion. The personnel files reviewed during the inspection showed mandatory training at 100%, with a wide range of other training undertaken and available for staff to complete for personal development.

The service used an on-call system that allowed for staff to be brought in, in the event of a staff shortage. Staff were 'matched off', in that a skilled member of staff would stand in for a skilled member of staff, or a therapeutic worker would stand in for a therapeutic worker.

We were told that activities were rarely cancelled, unless there was minimal residence interest, at which point the activity would be re-scheduled and those who were interested were guided to another activity. Activities were not cancelled due to staff shortage.

Assessing and managing risk to patients and staff

We reviewed seven care records during the inspection. Each record had a risk assessment and a crisis plan in place. Crisis plans were put in place at the start of the programme for each patient. The risk assessments were holistic, up to date, included plans for an unexpected exit from the programme, and risk had been shared with appropriate shareholders. The risk assessment tool was the risk assessment management plan (RAMP), devised by the provider. The plans were updated regularly, and if an incident occurred that required an amendment or update of the risk assessment. The service also provided an early leaver's pack, that ensured no patient who self-determined they were leaving the programme was abandoned without assistance being put in place, such as contact with care managers, probation services, or housing benefits. The service also offered charity beds free of charge for patients that had nowhere to go, until somewhere became available.

Good

Substance misuse services

Any deterioration in the health of a patient was acted upon immediately. We were provided with examples of situations where a patient was either taken to hospital or referred to a specialist team when either physical or mental health deteriorated. The service accessed local walk-in centres, and had a priority support agreement with the GP surgery that looked after patient health.

Challenging behaviour was identified by staff at the service or when out in the community, with response as soon as was practicable. This included rewards for stopping or changing negative behaviour, and reflection by the patient for poor behaviour; the service referred to the practice as 'positive or negative pull-ups', a reference to helping the patient pull themselves into a better state of mind.

The service had a policy on managing aggression. There were a set of house rules that each patient had access to, and these were agreed prior to the patient starting the programme. Restrictions included the taking of alcohol or drugs into the service, no weapons, items that would be expected; the list had been written with input from the patient community. We were told that police were rarely called to the service, due to the limited nature of any incidents that might require their input. Smoking was allowed in the smoking area at the back of the house, no smoking was allowed in the house, we saw evidence of smoking cessation information and access being offered to the patients at the service.

An agreement was signed at the assessment stage to inform the patient about the shared room policy. This also included the handing over of mobile telephones and electronic devices such as tablets on admission. There was a computer suite available for patients to use, and payphones and the staff office phones should patients wish to make calls. There were no televisions allowed in bedrooms, as the ethos of the programme was about social integration and sharing with other patients, as well as engagement with provided activities. Family visits were actively encouraged, with visiting days and times on Saturdays and Sundays.

The service kept a strict policy of supervised consumption of medication at the service, to avoid diversion of medication between patients. Action would have been taken against any patient who tried to divert, or share, medication. There was limited self-medication, other than the use of inhalers: there were two risk assessments on medication charts regarding the use of inhalers for patients at the service, completed and up to date.

The service tried to motivate patients not to take street drugs or alcohol when off or on the premises. The service viewed such incidents as being part of the recovery process.

Safeguarding

The service had a safeguarding lead in place and an up to date policy and procedure. The provider went to an external company with expertise in safeguarding procedures to review, update and implement new policy, as well as give training to staff. The registered manager and other senior staff knew the policy and how to apply it. Staff knew how to identify safeguarding issues, and how to follow up on discovery. There were no safeguarding alerts or concerns recorded by the service in the 12-months prior to inspection, but there was evidence that such concerns had been noted prior to that period. Safeguarding was noted to be a standing item on the weekly team meeting agenda. The service had strong links with the local safeguarding board for the area in which the service was located. It was noted that all staff had received safeguarding training at levels one to three for both adults and children as part of their mandatory training.

Staff access to essential information

The service used an electronic system to record care notes, specifically designed for substance misuse services. The service also maintained paper records as a back-up in case the computer system should fail or be unavailable. Paper records were kept secured in the main office in a locked cabinet, limiting access and ensuring patients could not access them.

The electronic system was available to all staff with access to the system, with sufficient numbers of computer terminals at the service. We saw signed paperwork from a patient was scanned into the system where electronic documents could not facilitate a signature. Staff told us the system was easy to use and we saw that information entered into the system was accurate and up to date.

Medicines management

The service had an up to date medication management policy in place, the policy due for next review in July 2020.

Good

Substance misuse services

Robust medicines management policies and procedures guided staff to appropriately manage medication. This included GP prescribing, storage, administration and disposal. We saw evidence in personnel files that staff had received relevant training. Further training and audits were also provided by the pharmacy that supplied medication to the service. When patients self-administered medication, such as inhalers, staff had appropriately completed self-administration risk assessments in line with best practice. We checked all 31 medication administration recording sheets at the service, and found that good practice was being observed.

Medication reconciliation started on patient arrival at the service, with their medication regime already uploaded onto the system. The medication was reviewed by the GP for the service, and a medication administration record updated and signed. Patients who required in-house detoxification were assessed and accepted by the Doctor who managed the detox regime. The detoxification doctor was the service GP who was on-site twice a week to monitor detoxification regimes. The GP also kept a record of the medication being administered to the patient. There were no nurse prescribers at the service. A medication lead was appointed at the service, and they ensured that medication was managed appropriately. This included a review of daily medication at evening medication times, to ensure that no patients had missed medication due to being off-site during the day.

The service used the clinical opiate withdrawal scale (COWS) for measuring physical symptoms during detoxification from drugs, and the clinical institute withdrawal assessment (CIWA) for patients undertaking alcohol detoxification.

Track record on safety

The service reported eight incidents that were classified as serious in the 12-months prior to the inspection. We reviewed these incidents and noted that the service acted appropriately. A recent incident at the service led to an outbreak of diarrhoea and vomiting among staff and patients, with the service immediately enacting a quarantine protocol and limiting visits to the site. The situation was quickly dealt with, and staff at the service were praised for their infection control actions and approach to the situation.

Reporting incidents and learning from when things go wrong

The service used an electronic reporting system for reporting incidents. The service had a lead staff member for incident reporting who could provide guidance or support to those using the system. All staff at the service could access the system which was used to report anything untoward. Patients were kept informed if anything went wrong that concerned either the patient as an individual or as a group. All reported incidents were directed to the appropriate manager for approval, investigation (if required) and actions. Incident reporting was also monitored centrally by a quality team who identified trends and training requirements. All serious incidents were investigated, and learning was shared within the team through team meetings. The service had a duty of candour policy in place, and we saw evidence in care records of consideration of duty of candour when passing on information to patients.

The staff team de-briefed after serious incidents. The provider incident, accident and near miss policy (to be reviewed in 2021) outlined the actions to be taken and included a de-brief for staff and patients and the support to be given.

Lessons learned were shared in community meetings with patients, staff team meetings, and by a quarterly 'lessons shared' message from the national service of the provider.

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

Good

Assessment of needs and planning of care

We examined seven care records of patients at the service. A comprehensive assessment was completed in a timely manner, and care plans were holistic and inclusive, with obvious patient input. There were full assessments of drug use, including injecting histories, any previous treatments, alcohol use, and blood borne virus assessments. Referral forms outlined substance misuse, physical health, mental health, medication, family and loved ones, parental status, finance, and criminal justice involvement. The risk assessment and management plan expanded this

information to formulate a holistic assessment. Consent and capacity were recorded, with confidentiality agreements on each record. Discharge plans were put in place immediately on admission.

We were told that the assessment would take about one and half hours to complete if all went smoothly. We saw in care records that physical examinations took place on admission, and as and when required during the programme. Physical health monitoring was also on-going at the service. We saw in care records that the GP was regularly checking files and patients. From a detoxification viewpoint, the registered manager said the service only managed the detoxification from a medically monitored approach, as all patients were expected to go to a specialist detoxification service prior to admission.

The service engaged with the local crisis team and other community teams to address patient mental, physical and social health needs, including counselling in sexual abuse and grief or bereavement matters.

Best practice in treatment and care

The service followed a residential treatment evidence base designed and created with university input, as well as following guidance from the 'Orange Book: Drug Misuse and Dependence', a nationally recognised guideline on clinical management. The service also used National Institute of Health and Care Excellence guidance, especially with relevance to medication management. The medication management policy quoted up-to-date guidance from the National Institute of Health and Care Excellence that included therapeutic drug and physical health monitoring.

The service used the therapeutic community model as the basis for its treatment programme. This included psychological interventions such as cognitive behavioural therapy and motivational interviewing. If a patient required more detailed psychological input, the patient would be referred to a local centre run by an NHS trust or another specialised service.

Care records showed good consideration of physical health care, and access to specialist services if needed. Several care records recorded instances of specialist assistance that had been accessed. Blood borne virus testing history was requested from the patient GP prior to admission, and would be available during the programme if required or requested.

Patients were supported to lead healthier lives. There was gym equipment available to all patients and staff. Meal menus highlighted healthy food options, with salad and fruit available at every meal sitting. Sports such as running, football, or general fitness was identified in the patient care record, and the patients were given options to take up their chosen sport. Smoking was allowed at the service, not within the building but in a designated smoking area. However, there was also guidance and literature available for patients in smoking cessation, something that staff routinely mentioned to patients.

There was an information technology suite with access to the internet for patients, as well as some direction from staff to help those who were not computer literate to better understand the options available.

Clinical outcomes were measured at the service. The care review process, involving the patient's care manager and key worker, provided outcome monitoring regarding the patient's quality of life which was recorded in care records. The service used treatment profile outcomes and outcome stars to monitor clinical outcomes. Monthly uploads to the national drug treatment monitoring service also provided analytical feedback regarding effectiveness of the service.

Clinical audits were carried out at the service, including medication audits by both staff and the external pharmacy, and infection control.

Skilled staff to deliver care

Personnel files showed that comprehensive inductions were undertaken by all staff. Sessional workers also had inductions to the service. An induction workbook was completed over a six-month period, this included interviews with senior staff and possible trips to other services as part of their training.

Staff were trained in specialist areas of support such as trauma-informed approaches, eating disorders, domestic violence and family support. Staff supported each other with their specialist knowledge when appropriate.

The multi-disciplinary approach at the service included attendance at meetings by the GP for the service, qualified staff and therapeutic workers (key workers), advocates, social workers, external care managers and coordinators, as well as the patient and family members. Care records showed that regular meetings were taking place during the programme for each patient.

Good

Substance misuse services

As part of their training, staff were required to take part in clinical opiate withdrawal scale (COWS) and clinical institute withdrawal assessment (CIWA) training, to monitor and prevent drug and alcohol related harm. The service had protocols in place for detoxification from alcohol, buprenorphine, diazepam and methadone. A blood borne virus nurse regularly visited the service to monitor patients.

The GP at the service was responsible for prescribing for different types of substance misuse problems. Regular team meetings occurred at the service, with input from staff clearly recorded. Staff had regular supervision, this was monitored and a record was placed in personnel files. Clinical supervision took place monthly, with operational supervision every eight weeks. Figures at the service showed that all staff received regular supervision. Annual appraisals were up to date, other than for four staff members who had only recently joined the service, and had yet to reach the required time at the service to receive an annual appraisal. Any performance issues would be dealt with by setting objectives and performance improvement plans.

Leadership training was not restricted to managers and was available to all staff at the service. There were two volunteers working at the service, recruitment information for volunteers was through the provider website. Volunteers could apply to be general or specific volunteers, applying to work with a particular group of patients or generally across the service. Volunteers went through the same induction process as other staff, and were supported senior practitioners at the service. Many the staff had previously gone through the programme at the service: the acting registered manager had been a patient at the service over 20 years previously, and had worked with the provider ever since.

In the 12-month period prior to the inspection, there had been eight quality related visits by senior staff and external auditors. This included unannounced health and safety audits, unannounced kitchen hygiene audits, and a GP annual review inspection.

Multi-disciplinary and inter-agency team work

The care records showed a multi-disciplinary approach. Clinical reviews were held weekly, with the GP attending the service twice a week. Records showed good relationships and close contact with external organisations. The service utilised links with family social workers who assisted in the use of the family room at the service or supervised family visits. Other external agencies were referred to when needed, including a local post-traumatic stress counsellor.

Early leaving plans were noted in care records. The plans outlined the services in the community to contact in the event of someone deciding to leave the programme. Each patient had contact details for all parties involved in their care whilst on the programme.

Adherence to the MHA and the MHA Code of Practice

The service did not accept patients detained under the Mental Health Act. However, the service recognised that some patients on the programme did have mental health diagnoses. Four members of staff had been trained in mental health awareness, and the service maintained close contact with the crisis team for the area, should a patient require more intensive assistance.

Good practice in applying the MCA

Training in the Mental Capacity Act was available to all staff. The training was for renewal every three years after completion. Staff we spoke to had a knowledge of the Mental Capacity Act, and knew the five principles.

During the referral process and the initial assessment, capacity was a consideration before acceptance into the programme. Patients on the programme had to have capacity to make decisions before acceptance. Patients requiring a Deprivation of Liberty Safeguards application were not accepted onto the programme. Protocols regarding consent and capacity were laid out in a service protocol, Mental Capacity and Deprivation of Liberty Safeguards Standard Operating Procedure from February 2016.

It was clear from the care records reviewed that patients were fully involved in decisions regarding their treatment, and consent was fully considered throughout the programme. Advocacy was available if required or requested, and the service directed patients towards two local advocacy services, with notices visible in the service. We were assured that, should a patient display signs of a deterioration in capacity, this would be given immediate consideration by the multi-disciplinary team before action would be taken.

Good

Substance misuse services

Are substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

We interviewed eight patients at the service during the inspection, and six members of staff. Patients told us that they 'loved' the service, and that staff were very supportive. Patients spoke of efforts by the service to ensure that, on discharge, they would have the best possible outcome regarding future care. One patient spoke of how the nature of the programme, keeping patients busy all the time, had worked well, the fact they were so busy helped them to 'ignore any cravings'. A patient spoke of how they were now thinking differently about their approach to life; they had changed in the months since admission. A patient who was accepted into the programme from another area of the country said they would like to stay in the area.

Patients said that the programme was not easy, but it was very effective. Patients said that key workers were always available, and that they could contact them when needed, and were approached regularly by key workers to ask how things were going. A factor that patients raised was that many of the staff at the service had recovered from substance misuse, and that they felt they could really relate to the position of the patients, and this made it easier for patients to trust them and confide in them.

A patient said that the sharing of the bedrooms had really helped with their social anxiety, they felt safe and likened the programme to 'parenting', which a patient said they felt they needed. Patients said they knew how to make complaints if necessary, and could raise concerns either privately or in community meetings.

Staff told us that they enjoyed working at the service, and felt that the programme they used was effective and interactive, leading to a successful stay for patients. Care records showed patient involvement in their treatment, and they said that staff would support them and answer any questions they may have. Patients told us of problems they had, and how they had been directed to treatment for those problems quickly and efficiently.

Patients said they trusted staff, and felt that confidentiality was important. The referral and assessment process outlined confidentiality, and told patients of how it worked both ways, staff and patients would respect information.

Involvement in care

Care records were written in a way that patients could understand their treatment plan, and patients told us that staff were always available to answer questions from them. Advocacy from two local services was available to patients, should they feel the need for their support. Care plans showed involvement of patients in their formulation.

Each patient had a recovery plan and risk management plan in place. Plans were amended during the programme for patients as the patient improved and progressed through the programme.

Care records showed that families of patients were involved heavily in the programme, and the service stressed the need for family involvement, should the patient be willing to include their family in their recovery. The treatment programmed agreed to by the patient was clearly explained prior to admission to the service. The patient welcome pack and noticeboards included information about treatments. This included information regarding patient rights. The service used a translation service if required and accessed a local multi-cultural centre for further assistance if required.

The model used for the treatment programme, the therapeutic community model, had a recovery focused basis that required lifestyle changes and input from the patient. The programme set personal objectives along the pathway, and patients were encouraged to take part in the programme fully to get the most from the programme, and to see that lapses in recovery were opportunities for learning.

Patients were encouraged to give feedback into the service. There was a complaints/compliments box at the service, that patients could access at any time. There was a patient forum, and patients were encouraged to attend morning handovers to talk about the previous day's events. The service ran an open-door policy for patients, making senior management available when needed.

Patients were involved in the interview of new staff, and received payment for their involvement. Family interventions were provided by the service to try to

improve family and patient relationships. Patients were encouraged to contact family during the programme, but it was not something the patient had to do if they did not want to. Prior to admission, families were given information regarding carer assessments, and how they could be accessed.

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

Good

Access and discharge

Waiting times to access the service depended upon funding for the patient, as such the service could not set a static response time for accepting a referral. An admission date was agreed that coincided with the visit of the service GP. If the patient was undergoing detoxification, then they had to be seen immediately on admission to the service. The service did have a waiting list. The list was managed at the service, with due consideration given to all factors regarding the urgency of the admission. Following treatment, should a patient not have somewhere suitable to be housed, the service would allow the patient to stay without payment at the service until suitable accommodation was found. Patients who did not arrive when expected had all reasonable attempts to contact them, with consideration of reasons for non-attendance considered as part of the treatment regime.

During the 12-month period between 1 October 2017 and 30 September 2018, the service had 117 admissions. During that time, 51% successfully completed the treatment programme, 40% were transferred to other services, and nine per cent discharged before completing the treatment. Transfer included referral back to case managers, other care services, and other residential services (for instance, the patient may have wanted to be somewhere closer to home).

The admission criteria for patients was clear and well documented. When a patient left treatment early, they were given an early leavers pack. This directed patients towards suitable support, as well as a protocol for the service for contacting all relevant parties in the provision of the treatment, including care managers, social services, and housing.

The service had an equality and diversity policy, due for review in September 2019, that stressed the need to embrace diversity, and to ensure that no-one was unfairly discriminated against because of their race, gender, gender reassignment, pregnancy or maternity, age, disability, sexuality, social standing, religion or belief, ethnic or national origin, marital or civil partnership status or because of responsibility for dependents. The service had experience of recently treating transgender patients, and were confident that the service treated all patients equally.

Risk management plans reflected the diverse needs of patients, and clearly showed pathways that were expected to be followed to facilitate successful discharge. There was discharge planning evident from admission, with up to date liaison with care managers. Patients requiring treatment at walk-in centres or hospitals were escorted and full support was given.

The facilities promote recovery, comfort, dignity and confidentiality

Patients at the service were aware of the requirement to share bedrooms as part of the treatment programme before admission. Sharing time and space with other patients was a key tenet of the therapeutic community model. Bedrooms were noted to be spacious, with storage space for each patient in their own section of the room. Bathrooms were not en-suite, but there were enough bathrooms and toilets for the number of patients on each floor. Patients told us that they enjoyed the sharing of the rooms, as it helped them to have people to talk to, rather than isolate themselves in their own space.

The service was located in a large house with a number of different rooms that patients could use to speak privately with staff. This included a large library area and many smaller rooms. The dining room area was newly refurbished, as were the kitchens. Fridges and freezers were checked, food was stored in date order. All kitchen staff had been trained in food hygiene. An activity area had a pool table and small kitchen. Snacks and drinks were available at any time. There was a faith and hope room. There was a therapy room with a massage bed, a massage chair, various soft lighting and seating. A former ball room with a sprung

dance floor was used for whole-residence group work, and had room for gym equipment and table tennis tables. A newly refurbished family room was available, equipped with toys for children and safe seating and table arrangements. We saw that the toys were kept clean as part of infection control compliance.

The service recognised that for many patients, pets were often the closest companion. The service ran a kennel and pet area on site for patients to keep their pets close to them during their stay at the service, believing this to be beneficial to patient recovery. At the time of the inspection there was one dog being kept at the service, and several smaller pets. The animal area was well maintained and cleaned regularly.

Patients' engagement with the wider community

The service at Phoenix Futures Wirral was piloting a new resident strategy that aimed at improving access to education and employment, as this was a key aspect of the therapeutic community model, with a view to rolling the strategy out to other services by the provider. There were measurable outcomes in that patients who had graduated from the service had gained employment at the YMCA hostel in the Wirral, jobs in the retail and hospitality sectors, as well as many former patients taking part in peer mentorship and health and social care courses. Former patients were returning to the service to complete observed practice and placement hours.

The treatment model used at the service relied on relationships to work effectively. Patients were encouraged to forge new relationships with other patients to strengthen the desire to recover. This was also aimed at familial relationships.

The service had access to external agency input, including activities such as recovery through nature, designed to help patients reconnect with nature to aid their recovery. This was achieved with help from various wildlife trusts.

Meeting the needs of all people who use the service

The service had two large accessible bedrooms for patients with mobility problems. The service used a language translation service when required, and had contact with a local multi-cultural centre for assistance with patients with cultural needs. Sign language expertise could also be accessed if needed. Printed information leaflets could be obtained. Information regarding drug and alcohol related harm was included in the information given to patients on admission, as well as from staff at the service and on noticeboards within the house.

We were told by patients and staff that activities were rarely cancelled, and never because of lack of staff. If patients chose not to attend an activity, then another activity would be considered as a replacement. Activities included recovery through nature activities, arts and crafts, reading and creating writing groups, as well as structured groups centred around building self-confidence, anger management, and relapse prevention.

Listening to and learning from concerns and complaints

The service had a compliments and complaints policy, due for review in May 2020, that outlined all actions to be taken in relation to complaints against the service or staff. This included a well laid out flowchart for the process to follow. In the 12-month period prior to the inspection, the service had received one formal complaint which was upheld but not referred to the Ombudsman. In the same period the service had received 15 compliments submitted on formal compliment forms, we were told this did not consider the many verbal compliments received by patients and their families.

We spoke to eight patients, they said they knew how to complain, however none of them had made a complaint since admission to the service. Staff told us the they received informal complaints, such as recently, whilst the kitchen was being replaced, patients were unhappy about the number of sandwiches they were getting, but after discussion about the situation patients accepted the rationale for the change in menu for a short period.

Complaint investigations were run within a specific time frame; seven days for the initial investigation (stage one); 21 days to compile the investigation in full; 28 days the appeal period depending on findings. At each stage, the complainant was contacted and the situation discussed either over the telephone or in person. This ensured that the complainant was kept informed of progress and involved in the process. Staff were informed at staff meetings, or in supervision. Lessons shared from across the provider portfolio was also shared with all staff by electronic mail.

Good

Substance misuse services

The service had monthly patient forums that were chaired by people who had completed the programme, and the minutes were shared with staff. This was another way in which dissatisfaction among patients could be raised and dealt with. The service had a service user charter, which outlined the protection of patient rights and the way in which they would be protected whilst at the service.

Are substance misuse services well-led?

Good

Leadership

Staff and the acting registered manager knew who the senior managers in the provider organisation were, and how to contact them if needed. We saw evidence that senior managers had visited the service, and one senior manager was present during the inspection and was interviewed. When the service was recently renovated, the chief executive was involved and helped to prepare the service for the return of patients from a week away from the service. The service had a clear vision of recovery and what it meant, and this was shared by staff across the service. Managers at the service had knowledge and experience to enable the service to operate effectively.

The managers had the experience and skills needed to run the service. The provider had a fit and proper persons statement for employees, trustees and board members that outlined the requirements to be employed at the service. The provider also had a fit and proper person check list that included a register of skills of board members, and other key details.

The acting registered manager told us that there were opportunities for the registered manager at the service to have leadership development, as well as other staff. The head of house at the service had a master's degree in leadership and development. The provider had recently launched a new learning and development programme called Future Learn. The programme provided a wide range of flexible learning opportunities, including sessions provided by provider senior managers. For example, a leadership workshop was delivered by the provider chief executive.

Vision and strategy

All staff interviewed during the inspection knew the vision and strategy for the service. The provider carried out annual roadshows, attended by staff and personnel including the chief executive. Staff opinions were taken and listened to, and staff and patient consideration was given to the overall strategy for the service. The new residential strategy was developed with input from staff, patients and stakeholders, aimed at improving the service, including aftercare support to ensure former patients were not without a fall-back should they begin to relapse, mutual aid support groups for graduates of the service, and Phoenix family, whereby emphasis would be placed on small family group sessions, open days and events.

Each staff member had a job description, and knew about their role in the service.

Culture

All staff interviewed felt respected and supported at the service. There was an employee helpline at the service, so staff at the service who felt stressed or in need of reassurance could get support. There was a staff awards scheme called New Year Honours, a national scheme that recognised the good work of staff across the provider sites. The acting registered manager told us they felt supported by senior management, as did the staff we spoke to at the service. Staff said that they enjoyed working at the service, several were former graduates of the programme, they felt they were playing an important part in helping others.

Personnel files showed opportunities for career and professional progression, with staff being actively promoted to gather more qualifications that could help the service and themselves. The provider had launched a new learning and development programme called Future Learn, designed to provide a wide range of flexible learning opportunities.

There were no bullying or harassment cases reported in the 12-months prior to the inspection. Staff we spoke to knew how to use the whistleblowing process, and felt able to raise concerns without fear of victimisation. We were told that the relationship with senior staff and the team were very good.

Governance

The service used key performance indicators to gauge performance at the service and across the provider sites. The indicators were presented in an easy to read report, as

well as in a format called the Phoenix Futures balance scorecard, and summarised the key performance measures deemed most relevant to display service progress. These were received electronically, reviewed by senior managers, and related to the team. Indicators included treatment completion data, residential not treated and transferred, incomplete exit, treatment profile outcome measures, black and minority ethnic patients, sickness rates, grievances, disciplinary, and vacant posts. There was also a graph outlining outcome star results, used for both supporting and measuring change. The information was used to identify both successes and shortfalls with a view to improve the service by actively concentrating on how to make the service better.

There was a governance policy and manual in place at the service, updated in 2018, a comprehensive document that outlined good governance, role of the board of directors and officers, board review and renewal, and board and committee structure. There was also a corporate social responsibility policy in place, about ethical management, going beyond minimum legal requirements and giving back to society. Board minutes were reviewed, as was the board assurance framework, and the board strategic risk register.

We saw evidence of investigation regarding serious incidents, and implementation of actions regarding findings from such investigations. The service completed clinical audits. These led to improvements when problems were identified.

Notifications were submitted when required. Staff knew and understood the arrangements for working with other services to ensure the needs of patients were met. There was a whistleblowing policy in place.

Management of risk, issues and performance

There were clear quality assurance management and performance frameworks in place that were integrated across all organisational policies and procedures. There was a provider risk register, an action plan risk register, and a board strategic risk register. These included quality monitoring and continuous improvement plans. The Wirral continuous improvement plan had last been reviewed on 17 January 2019. Minutes of board meetings reflected quality monitoring. Should staff have concerns regarding risk, they could submit those concerns to senior management for consideration for inclusion in the risk register.

Financial considerations were included in risk registers and as a key part of the overall management strategy, as the service operated as a not-for-profit charity and housing association. There were no indications of financial pressures having a debilitating effect on the service at the Wirral.

Sickness rates and absence rates were monitored at the service. There was a residential services quality and performance monitoring schedule in place, outlining monitoring methods, frequency, who compiled and reviewed evidence, and how it would be reviewed.

Information management

Information technology in the form of computers and electronic systems was in place at the service. These were used to maintain care notes, compile data and in the general running of the service. There was an information technology suite that patients could access with wi-fi available at the service. The electronic care record system was seen to be effective, and maintained limited access and confidentiality restricted to those with legitimate access.

Team managers had access to the information they required to carry out their role and ensure patient safety and treatment. We saw evidence of contact with external bodies, such as care managers and local authority services.

Engagement

The service had annual roadshows that gave staff the chance to feedback on services, as well as staff surveys. Patients and families could attend these and access information through the website for the provider.

We saw staff meeting minutes for the three months prior to the inspection, and saw that staff were given opportunity to raise issues that were then followed up before the next meeting. We reviewed minutes from patient forum meetings for the months leading up to the inspection. The patient forum meetings showed that patient opinion was taken and considered. There was also a service user satisfaction survey carried out twice a year for the provider. We reviewed the service user satisfaction survey for 2018,

Good

Substance misuse services

60% of those surveyed rated the service as very good, 25% rated the service as excellent. Ninety per cent of those surveyed would recommend the service to a friend family member.

Phoenix family was a new approach aimed at bringing family members together at the service. It included family mediation and family discharge planning. Carers were encouraged to give feedback to the service at these events and during the programme.

The service contributed to external and system reviews across partnerships as required, this was noted by details of quality visits and audits, including an annual provider audit carried out by an NHS trust in the South East of England. The service had over 30 referring bodies and stakeholders from all over the country.

Learning, continuous improvement and innovation

The service liaised with a local public health group regarding drug and alcohol review processes. The service had continuous improvement plans in place, the Wirral continuous improvement plan had last been reviewed on 17 January 2019.

Staff could recognise their colleagues' achievements as part of a national awards event called New Year's Honours. Staff who went 'above and beyond' were recognised by individual and team awards and their achievements were communicated across the charity.

At the time of inspection, the service was not involved in any research or innovation programmes.

Outstanding practice and areas for improvement

Outstanding practice

The service provided for patients who were not yet approved accommodation as they finished their funded programme, by allowing patients to stay without charge until the accommodation was dealt with.

The service also recognised the attachment that some patients had for their pets, and accommodated those pets on site in kennels and a variety of hutches for smaller pets. This allowed patients to maintain contact with their pets, for some patients the only companionship they had.