T.H.O.M.A.S Drug & Alcohol Rehabilitation Unit

Quality Report

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

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

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

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

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

Overall summary

We do not currently rate independent standalone substance misuse services.

We found the following areas of good practice:

- The building was clean, well equipped and safely maintained. Clients took part in a cleaning rota. Staff completed building safety assessments and regularly inspected equipment and facilities.
- The building offered appropriate facilities including communal areas, lounges, group rooms, kitchen and laundry facilities and access to outdoor space. Clients told us the building had a homely feel and that the environment was welcoming.
- Staff were supported to deliver care. Compliance with mandatory training was high. There was access to additional specialised training. Staff received regular clinical and managerial supervision and an annual appraisal.

Summary of findings

- Clients received a comprehensive assessment on admission. They were involved in the development of their care plans and decisions about their treatment. Care plans were recovery focused and reflected the clients goals and objectives.
- Recovery was embedded in the delivery and culture of the service. Clients played an active role in their care and were supported to develop recovery capital. This included the development of life and social skills as well as engagement with other support services.
- Care and treatment was underpinned by best practice. Peer mentors were a visible presence in the service. Clients had access to psychological therapies, group sessions and mutual aid groups.
- Clients we spoke to were positive about the service they received. They spoke highly of the staff that were treating them. Clients felt the service was supportive and recovery focused. They were optimistic about the treatment they were receiving.
- There were clear processes for access and discharge from the service. The service worked with referral agencies to ensure appropriate admissions. Clients had discharge plans and were linked in with support services in the community.
- The service had a clear set of vision and values. Staff were aware of these and reflected them in their daily practice.
- Staff morale was positive. Staff felt supported by senior management within the service and the provider organisation. Senior managers were visible to staff and were considered approachable and open. There were low absence rates and an open and honest culture.
- There was a governance structure to support the delivery of care. The service monitored performance through the national drug treatment monitoring system. Senior managers carried out regular quality checks at the service.

Summary of findings

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Background to T.H.O.M.A.S Drug & Alcohol Rehabilitation Unit

T.H.O.M.A.S Witton Bank is a 21 bed drug and alcohol rehabilitation unit based in Blackburn, Lancashire. The service provides residential psychosocial rehabilitation to males aged between 18 and 55. There were 17 clients when we visited. Clients who attend Witton Bank have already completed a detoxification programme, which means they are no longer actively using alcohol or illicit substances. Witton Bank provides a 26 week rehabilitation programme followed by the option of a further six months in a secondary community based programme.

Witton Bank is one of three T.H.O.M.A.S services registered with the Care Quality Commission. It has been registered since January 2011. The service is registered to provide accommodation for persons who require treatment for substance misuse and for the treatment of disease, disorder and injury.

The service has previously been inspected, in December 2012 and in October 2013. The service was found to be fully compliant with standards on both inspections.

Our inspection team

The team that inspected the service comprised of a CQC inspector, a CQC assistant inspector and an expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using, substance misuse services.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, asked other organisations for information, and gathered feedback from staff members in response to an email we asked the provider to send to them.

During the inspection visit, the inspection team:

- visited Witton Bank and looked at the quality of the physical environment
- observed how staff were caring for clients
- spoke with six clients

Summary of this inspection

- spoke with the registered manager
- spoke with five other staff members employed by the service provider
- looked at seven care and treatment records
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

Clients we spoke to were very positive about the care and treatment they received at the service. They considered staff to be compassionate and interested in their wellbeing. Clients told us that staff were approachable, empathetic and non-judgemental in their approach. Some staff members had lived experience of substance misuse and clients told us they found this valuable.

Clients told us that they were involved in decisions about their care and were encouraged in their recovery. Clients told us that the service provided a supportive environment and they were optimistic about their treatment. They felt that the service provided a high level of personalised care and told us that they would recommend the service to others.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The building was clean and well maintained. Furniture and décor was appropriate and in good condition.
- There were appropriate checks to ensure the safety of the building. Health and safety and fire risk assessments had been completed. There was a programme of inspection for equipment and facilities. Where required this was conducted by external specialists for example gas safety checks.
- The service was well staffed. There was no use of agency staff. There were sufficient staff to ensure that clients could access the full range of available treatments and support.
- Staff received mandatory training to support them in their role. Compliance with training was good.
- Staff completed client risk assessments on admission. Assessments had been reviewed and updated. Clients played an active part in risk assessment and were able to tell us what their risk assessments contained.
- The service had effective systems and processes to ensure the safe storage and administration of medications. Medication administration records were completed and up to date.
- There was a process to report and learn from adverse incidents. Incidents and lessons learnt were a standing agenda item on team meetings. Learning from across the organisation was shared at operational manager meetings

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients received a comprehensive assessment as part of their treatment. Assessments we reviewed were comprehensive and reflected in care planning. Clients played an active part in their assessment and were able to tell us what their assessments contained.
- Care plans were regularly reviewed and up to date. They showed client involvement and were recovery focused. Care plans identified the client's goals and objectives.

Summary of this inspection

- The service offered a range of evidence based psychosocial interventions for clients, in line with national guidance. Staff were appropriately trained and had the experience to deliver sessions.
- Staff received regular supervision. Clinical supervision was provided by an external psychologist. Staff received an annual appraisal and had work objectives.
- There were good links with other organisations. These included health care providers such as GPs and other recovery agencies. The service was part of the local recovery community.
- The service employed people with lived experience of substance misuse as peer mentors. This was in line with best practice. Clients told us the presence of peer mentors was a positive and motivational factor.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients we spoke with were positive about the staff. They considered staff to be caring, knowledgeable and committed.
- We observed staff treating clients with kindness, dignity and respect.
- Clients told us they were actively involved in their care. We saw evidence of client involvement in the care records that we reviewed.
- The service encouraged client feedback. There was a monthly community meeting where clients could voice concerns and there was a suggestions box.
- The service encouraged clients to have a say in the running and development of the service. Clients had been part of interview panels for new staff.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The service had eligibility criteria. This ensured that only individuals who were in a position to benefit from the treatment offered were admitted.
- The service had a target to respond to referrals. The service was meeting the target
- There was a clear discharge process for clients. Clients attended discharge meetings and were linked in with support services. T.H.O.M.A.S provided its own secondary programme for clients

Summary of this inspection

- The service carried out follow up conversations with clients seven days after their discharge. This helped check on client's wellbeing and safety.
- The service had an assisted bedroom and bathing facilities for disabled clients or those with limited mobility. There was access to translation services if these were required.
- There was a complaints process. Clients were aware of how to complain and staff were able to describe the complaints policy.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The provider had a set of vision and values. Staff were aware of these and reflected them in the delivery of care.
- There were a range of policies to support the delivery of care. These had been reviewed and were in date
- The service monitored performance through engagement with the national drug treatment monitoring service. This was supported a series of internal audits and quality visits from senior management.
- Staff morale was positive. Absence rates were low and there were no cases of bullying or harassment. Staff told us that management were supportive and that they enjoyed their roles.
- There was an open and honest culture in the service. Staff told us they could raise concerns without fear of victimisation and that senior managers were open and approachable.

Detailed findings from this inspection

Mental Health Act responsibilities

The service was not registered to accept clients detained under the Mental Health Act. If a client's mental health were to deteriorate, staff were aware of who to contact.

Staff received mental health awareness training as part of National Vocational Qualification training courses. This meant that they were aware of signs and symptoms of mental health problems.

Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the service provider's compliance with the Mental Capacity Act 2005 and, where relevant, the Mental Health Act 1983 in our overall inspection of the service.

All clients who were admitted to the service were presumed to have capacity to undertake the rehabilitation programme. Staff received Mental Capacity Act awareness training as part of National Vocational Qualifications training courses. If there were concerns over an individual's capacity staff were aware of who to contact. Further information about finings in relation to the Mental Capacity Act appear later in this report.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

Witton Bank was located over four floors. The building was clean and well maintained. Clients joined a cleaning rota and took responsibility for the upkeep of the building and communal areas. Completed rotas showed that the building was cleaned daily. Clients were responsible for the cleanliness of their own bedrooms.

There was an up to date health and safety risk assessment. Identified actions had been followed up. Electrical items had been tested and were in date. There were certificates to evidence that gas safety and electrical wiring checks had been undertaken by an approved individual. A legionella risk assessment had been completed by an external firm and there were regular checks of water samples. There was a fire safety risk assessment. There was a schedule of regular checks of the fire alarm and detection systems. Fire extinguishers were in date and checked annually. Staff received bi-annual fire safety training. At the time of the inspection seven out of nine staff had completed training. There were identified fire wardens. Evacuation drills had been held.

First aid boxes were located on each floor of the building. First aid boxes were checked and refreshed regularly. Eight out of nine staff had completed first aid training. The manager was a registered nurse. We observed staff and clients following good infection control practices. Hand washing posters were on display. All of the staff had completed infection control and blood borne virus training.

There were visible ligature points in the building and in bedrooms. The provider told us they did not admit clients with high level mental health concerns or who were deemed to be at risk of self-harm. This was included in referral documentation and covered on assessment.

There were 15 bedrooms including a single assisted bedroom on the ground floor. Seven of the bedrooms were dual occupancy and seven were single occupancy. One of the bedrooms had an en suite shower. There were six other shower and bathing facilities which were shared by the remaining clients. Clients were informed of these arrangements prior to admission.

Safe staffing

Witton Bank employed nine staff. These included a registered manager, key workers, group facilitators and administrative support. There were five key workers providing three whole time equivalent posts. The unit was staffed 24 hours a day seven days a week. Clients could seek support from staff at any time.

The service did not use agency staff. The T.H.O.M.A.S organisation employed one bank worker who provided floating cover across their sites. Any staff illness or absence at Witton Bank was covered either by existing staff or by utilising the bank worker. The bank worker had experience of working at Witton Bank and was known to the clients. Annual leave was planned in advance to ensure appropriate staffing cover was available at all times.

There was a programme of mandatory training. Compliance with training was high. All staff had completed health and safety, information governance and infection control and blood borne viruses training. At the time of the inspection eight out of nine staff had completed first aid and food hygiene training. Seven out of nine staff had completed medicines management and fire safety training. A training matrix was used to monitor compliance and record renewal dates.

Assessing and managing risk to clients and staff

We reviewed seven care records during the inspection. Risk assessments were completed in all of the client files we looked at. Assessments had been updated and risk

management plans reflected the findings of the risk assessment. We saw evidence of plans being updated to reflect changes in circumstance. We spoke to six clients during the inspection. All of the clients confirmed that they had a risk assessment and were able to tell us what it included.

All staff received safeguarding training as part of their mandatory training programme. Training was delivered on-line by Blackburn Council. At the time of the inspection the service was 89% compliant with safeguarding training requirements. Staff we spoke with displayed a sound knowledge of safeguarding procedures and understood their responsibilities in raising safeguarding concerns and alerts. There were safeguarding policies to support staff in this regard. The service had good relationships with local safeguarding teams and authorities. Staff attended local multi-agency risk assessment conferences. Multi-agency risk assessment conferences are local victim focused meetings where information is shared on the highest risk cases of domestic violence and abuse between different statutory and voluntary sector agencies and providers. Staff had also attended 'making every adult matter' meetings with local authorities.

There were clients in the service who were on medication. However, the service itself did not prescribe medications. Clients could self-administer but staff also administered medications. There was a medication policy to support this process. The policy detailed the appropriate checks that must take place prior to administering medication. Medication administration record sheets were present for clients on medication. The medication administration record sheet is a legal record of medication administered to an individual. The medication administration record sheets were completed and up to date. They included photographs of the relevant client to aid correct identification. The service had appropriate facilities for the storage of medications including controlled drugs. However at the time of the inspection the service did not have clients who were taking controlled drugs. There were processes for the ordering and return of medications and good links with a local pharmacy that supported the service. Regular audits of medication took place.

Track record on safety

Between June 2015 and June 2016 there had been no serious incidents that required investigation. There was a process to report and investigate such incidents should they occur.

Reporting incidents and learning from when things go wrong

Staff recorded adverse incidents in patient notes and in a separate adverse incident file. We reviewed the adverse incident file and saw that incidents were appropriately recorded. Staff understood the type of incidents that should be reported, including safeguarding, incidents of violence and aggression, broken equipment and health and safety matters. Incidents and lessons learnt were a standing agenda item for the weekly team meeting. The team meeting provided a space for reflective practice and enabled staff to consider how incidents could have been handled differently. Incidents were also discussed at the providers monthly operational managers meeting. This ensured that learning was shared across the T.H.O.M.A.S organisation.

Duty of candour

Duty of candour is a statutory requirement to ensure that providers are open and transparent with people who use services in relation to their care and treatment. It sets out specific requirements that providers must follow when things go wrong with that care and treatment. This includes informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. There had been no recorded incidents that required a formal apology. The service did not have a specific duty of candour policy. Staff showed a good understanding of their responsibilities to be open and transparent with people in relation to care and treatment.

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

Assessment of needs and planning of care

Staff completed comprehensive assessments on new clients entering treatment. Assessment documentation covered a range of domains and captured clients' needs and viewpoints. The assessment included current and historic use of substances, previous treatment, physical health, mental health, social circumstances, forensic

history, the client's family situation including children and client objectives and goals for treatment. We spoke to six clients during the inspection. All of the clients confirmed that they had an assessment and were able to tell us what it included. Clients completed psychological and social self-assessments as part of the assessment process.

We reviewed seven care records during the inspection. Assessments were completed in all of the client files we looked at. Assessments had been updated and were reflected in the clients' recovery plans. All of the seven records we reviewed had a recovery plan. Recovery plans were comprehensive and up to date. They were personalised and captured the individual's views. They were recovery focused and captured information on the client's strengths and goals.

Records were stored in paper form. Paper based records were stored securely in lockable cabinets. This meant that records were stored securely and that information and data was protected.

Best practice in treatment and care

Witton Bank delivered care in line with the 12-step programme. The 12-step programme was developed by the alcoholics anonymous fellowship. It utilises principles of mutual aid and peer support. The National Institute for Health and Care Excellence has produced guidance for services managing clients with substance misuse issues, such as guidance on drug misuse in over 16s: psychosocial interventions (NICE CG51) and guidance on alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE CG 115). The guidance recommends that staff routinely provide information about mutual aid groups and facilitate access for those who want to attend. Mutual aid groups bring together people with similar problems and experiences to help each other manage and overcome their issues. The evidence base shows that clients who engage with mutual aid are more likely to sustain their recovery. Witton Bank's weekly programme included access to alcoholic anonymous and narcotics anonymous meetings three times a week.

Witton Bank offered a set weekly timetable of activities and therapies for clients using the service between Monday and Friday. Activities also took place over weekends but these varied. Weekend activities were discussed and agreed with staff on a Thursday. Weekends were used for visiting and clients were also able to access gym facilities. The activities programme included group therapies, 1:1 counselling, mindfulness and cognitive behavioural therapy. The content and delivery of the group sessions followed best practice guidance from the National Institute for Health and Care Excellence (NICE 51: drug misuse in over 16s psychosocial interventions).

The service worked with clients to help them develop recovery capital. Recovery capital refers to social, physical, human and cultural resources a client needs to develop to help them achieve and sustain their personal recovery. Clients told us that the groups and sessions they attended had helped them understand and manage their health and social needs. They were able to explore the reasons behind their substance misuse and develop coping strategies. Clients linked in with other organisations and were encouraged to develop their social support including mutual aid. Sessions also included life skills such as cooking. These helped clients build the skills required to help them function and maintain their independence when they returned to the community.

Alongside engagement with mutual aid, the Strang Report (National Treatment Agency 2012) recommended that services use peer mentors to make recovery a visible presence to those still struggling with addiction. Peer mentors are individuals who have been through their own substance misuse treatment and are now in recovery. They provide a positive example to clients of the benefits and possibilities of recovery and use their own experiences to engage with and support clients in their own recovery.

Clients who had previously been through Witton Bank's rehabilitation programme and were now in the second stage of treatment with T.H.O.M.A.S attended the service to act as peer mentors. The second stage treatment was the option of a further six months community-based rehabilitation with T.H.O.M.A.S in semi-independent living. There were five active peer mentors at the time of our inspection. Clients we spoke with told us that the peer mentors within the service were a motivational factor for them and provided them with an example of what they could achieve. Three of the clients we spoke to told us they wanted to be peer mentors in the future. The service also utilised volunteers with lived experience of substance

misuse. Peer mentors could apply to be volunteers once they had finished their second stage treatment. There were three former clients completing the volunteer course at the time of our inspection.

Witton Bank did not provide a physical health service and had links with a local GP to manage physical health concerns. The service had an effective relationship with the GP and encouraged clients to register as patients. Clients were supported to attend appointments at the GP, dentist or other health appointments as required. A dental nurse attended every six months to run oral hygiene sessions. The service had recently admitted a client with diabetes. They had worked with the GP and local diabetes service to ensure their needs were met and their condition was managed.

The registered manager audited care plans on a monthly basis. Discussions around the quality of record keeping and care plans were held in 1:1 supervision sessions and within team meetings.

The service utilised an outcome star chart to monitor client progress during their treatment. The outcome star required the clients to score themselves against 10 key domains including motivation and taking responsibility, relationships, health and addictive behaviour. The client was required to score themselves out of 10 for each domain. They repeated the exercise in 1:1 sessions and care reviews. The scores could then be plotted onto the star chart. The star chart provided a graphic illustration of clients progress as well as a quick guide to areas they needed to work on.

Witton Bank also measured outcomes using the national drug treatment monitoring service and treatment outcome profiles. Treatment outcome profiles measure the progress of clients through treatment. They are completed at least every three months and form part of the national drug treatment monitoring system. The national drug treatment monitoring service is managed by Public Health England. It collects, collates and analyses information from those involved in the drug treatment sector. All drug treatment agencies must provide a basic level of information to the national drug treatment monitoring service on their activities each month. Providers are able to access reports and compare performance against the national picture.

Skilled staff to deliver care

Staff had the necessary skills to carry out their duties and deliver care. Some staff members had lived experience of substance misuse. All staff underwent an induction process and were given orientation training in accordance with drug and alcohol national occupational standards. Key workers were supported to achieve a level three National Vocational Qualification in care qualification and to undertake level four and five courses. One staff member had become a qualified counsellor. Additional training around mindfulness, cognitive behavioural therapy and group facilitation was also available. The manager had completed a level five National Vocational Qualification in leadership and management.

Staff received regular supervision. Clinical supervision was provided fortnightly and the service contracted an external clinical psychologist to provide this. Managerial supervision took place every six weeks. We reviewed supervision records and found that supervision was taking place as required. Staff told us they found the supervision to be of a good quality and helpful to them in their role. All staff had received an annual appraisal.

Human resource support was provided by an external company. There was a policy and process to manage staff performance and disciplinary issues. There were no staff on performance management at the time of our inspection

Multidisciplinary and inter-agency team work

Staff attended a handover meeting at the start of each shift. There was a discussion about each client as required and any issues from the previous shift were shared. Staff had access to a weekly team meeting. The team meeting covered both clinical and operational issues. Actions from previous meetings were followed up and staff were encouraged to discuss any issues. We saw that information from provider level meetings was shared within the team meeting.

The service had effective working links with external services including the local GP, pharmacy and dental services. There were positive relationships with local safeguarding authorities, social services and criminal justice services including probation.

The service had strong links with the local recovery community and services. These included alcoholics anonymous, narcotics anonymous and voice. Voice was a local client led therapeutic group. There were strong links with local community groups and facilities. This included

patients attending courses at local colleges, going to the gym and attending a local community centre. The community centre provided a range of activities that clients could engage with including a gardening group. Clients were also able to access art therapy sessions. This was run in conjunction with a local scrap art material store. Clients had previously displayed their art work at an exhibition at Blackburn museum. Clients were also able to volunteer at a local charity shop ran by T.H.O.M.A.S.

Good practice in applying the MCA

All clients who were admitted to the service were presumed to have capacity to undertake the rehabilitation programme. The Mental Capacity Act was not part of core training. However, staff completed National Vocational Qualification courses that included basic training. If staff had concerns over a client's capacity these would be discussed with the referring agency or, if the client had already been admitted, with the GP. Staff were aware they could refer individuals into mental health services through the local single point of access service.

Equality and human rights

There was an equal opportunities and diversity policy that covered protected characteristics under the Equality Act 2010 and definitions of discrimination. The policy had been reviewed and was in date. The service provided briefing sessions for staff on equality issues. We spoke to staff members who had attended sessions and received equality and diversity training.

Clients we spoke to told us they did not have specific cultural or diversity needs but they felt that staff would respect and respond to individuals that did.

The service had some blanket restrictions. There was a blanket restriction on visits by individuals in active addiction. This was appropriate due to the nature of the service being provided. Clients were also unable to make phone calls or receive visits during the first three weeks of treatment. This was to ensure that they focused on treatment. Restrictions were explained to the client prior to admission and included in the residents' handbook.

Management of transition arrangements, referral and discharge

The service accepted referrals from NHS and third sector substance misuse services, criminal justice services and local health and support agencies. The service liaised closely with referring agencies to ensure the appropriateness of referrals. We spoke with six clients. Five of the clients felt that the transition from their previous service had been well managed. The sixth client did not comment.

There was a clear process for discharge. A 'moving on' review meeting was held with each client a month before their discharge. The meeting included the client, key worker and a representative from the agency funding the treatment if applicable. The 'moving on' review meeting was used to confirm the agreed aftercare package and discuss any outstanding actions or issues from the clients care plan. The service offered a six month follow on programme in semi-independent living called 'second stage'. The programme was not mandatory and clients could decide to pursue alternative options if they wished too.

Records we reviewed evidenced that the service worked with partner agencies to facilitate access and discharge. We spoke to six clients. All six clients had a discharge plan. The clients understood the content of their discharge plan. We spoke with two clients who were approaching their discharge. Both clients told us that they had attended meetings about their discharge. Both clients told us that they had been linked in with support services as part of their discharge plan

Are substance misuse services caring?

Kindness, dignity, respect and support

We observed positive interactions between staff and clients. Clients were treated with compassion and understanding. They told us they felt supported emotionally and practically. Staff were approachable and engaged with individuals in a respectful and dignified manner. They showed a good understanding of individual need and circumstance. They were person centred in their approach and able to use their own experiences of substance misuse to engage with clients and develop effective therapeutic relationships. A therapeutic relationship is a relationship between a worker and a client that is built on mutual trust and respect with the aim of bringing about beneficial change.

The service had a confidentiality policy. The importance of confidentiality was discussed with clients during admission.

The involvement of clients in the care they receive

There was an admission process to inform and orientate clients to the service. Clients were able to visit prior to admission to view the service and speak to staff and peers. This allowed the client to ensure that the service was appropriate for them before admission. The service provided a welcome pack for clients, which included information on the service, its aims and objectives, house rules, expected standards of behaviour and the complaints process. A sample copy of the activities schedule was also provided.

Clients told us they were actively involved in their care. They identified that they had developed their own sets of goals and objectives. We reviewed seven care records. All of the records evidenced client input and reflected their stated objectives and treatment goals. Clients had a clear understanding of what was in their care plan and had signed to confirm their involvement. Copies of care plans were available to clients. Where clients had requested the involvement of family members or carers this had been facilitated. Clients were allowed visitors after three weeks of residency at Witton Bank. After three months clients were assessed for weekend home leave.

Clients were able to feedback on the service they received in a variety of ways. There were monthly community meetings. The meeting gave clients the opportunity to feed back to staff and raise any issues. In addition clients were encouraged to complete evaluations of group sessions and client satisfaction surveys. There was also a comments and suggestions box in communal areas. Clients told us they were also able to feed back issues informally to staff on a day-to-day basis.

Clients were involved in decisions about the service through the monthly community meeting. Clients had also been part of interview panels for permanent staff and individuals applying to be volunteers with the service.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Access and discharge

There were eligibility criteria to access the service. This meant that the service only admitted clients who were in a position to benefit from the treatment on offer. Clients completed a detoxification programme prior to entering the service. Individuals who had been referred were encouraged to attend the service as part of the assessment process. They were able to speak to staff and current clients. This enabled the individual to see how the service worked and ensured that they understood the underpinning treatment philosophy. This included an explanation of the house rules and expected standards of behaviour. Individuals were also given a copy of the residents handbook which provided further information. This meant that clients were able to decide if the service fitted their own needs before committing to admission.

The service had a target to assess referrals within seven working days and no longer than 10 working days. The service was meeting this target. A decision on the assessment and potential offer of a place was made within two working days of the assessment taking place. This allowed the assessment to be discussed by staff prior to a decision being made.

Between June 105 and June 2016 the service had discharged 56 clients. The service carried out follow up sessions with clients within seven days of their discharge. This was usually undertaken by telephone. The follow up process allowed the service to ensure that the client was safe and well. Clients were able to get advice and support around any issues that they may have been experiencing post discharge. The service had successfully contacted 89% of those clients within seven days of discharge.

The facilities promote recovery, comfort, dignity and confidentiality

The building was comfortable and homely. Art work produced by clients was displayed on the walls and there were testimonies from previous clients who had completed treatment. Clients were able to access a range of facilities within the service. There were three separate lounges, a dining room, a conservatory and two group rooms. In

addition, there was a music room and a pool room available for clients to use. A range of books and games were available for clients if they wanted to relax. There was access to outside space including an area that was used for exercise and five a side football.

There was access to kitchen facilities and laundry facilities. Clients were part of a rota to cook for the house. This included planning menus on a weekly basis. There were set meal times with refreshments available in between. Clients ate together in a communal dining area.

Clients were able to personalise their bedrooms by displaying photographs and posters. Some clients were in shared rooms. Clients were made aware of this arrangement prior to admission. We spoke with clients who were in shared bedrooms and they were happy with the arrangement. Bedrooms had secure storage spaces that clients could use. Clients were also able to give personal items to staff for safe storage.

Clients were able to make telephone calls in private if they wished to. However, telephone calls were not allowed during the first three weeks of residency. This was to ensure that they focused on treatment and was explained to clients prior to admission.

Information about the local recovery community and recovery services was available to clients. Clients were also given information on other services and activities such as local college courses.

Meeting the needs of all clients

The service had an assisted bedroom on the ground floor with access to shower and appropriate bathing facilities. The remaining bedrooms were on the first and second floors of the building. All group rooms and facilities were located on the ground floor.

Staff were able to access translation services, including sign language. Information leaflets and documentation could also be translated if required. However, the service noted that if a client did not speak English they would discuss the suitability of the service with them and the referring agencies. This was due to a potential concern over the client's ability to participate in group work and the treatment programme if they did not speak English.

Staff supported clients with their religious and cultural needs. Clients were supported to attend local places of worship in line with their religious beliefs.

Listening to and learning from concerns and complaints

The service had a complaints policy. The policy covered both verbal and written complaints. Information on how to complain was included in the service welcome pack and was also displayed within the premises. We spoke with six clients. Four of the clients knew how to complain but the remaining two were unsure. However, they stated they would raise their concerns with staff and the registered manager. All of the clients we spoke with told us they were confident any complaint would be managed properly. We spoke with six staff members. All six were aware of the complaints process and policy and were able to assist clients if they wished to raise a concern.

The service had received one complaint between June 2015 and June 2016. This complaint was not upheld. Although it had not been required, the registered manager was able to describe the process to instigate a complaint investigation. There was also a process to feedback learning through supervision and team meetings.

Between June 2015 and June 2016 the service had received 31 compliments. These were in the form of 29 thank you cards and two thank you letters from family members.

Are substance misuse services well-led?

Vision and values

The T.H.O.M.A.S organisation had a mission statement. This was to 'strive to provide a multidimensional approach to recovery that encompasses our core values. Our programmes of rehabilitation, support, intervention and advice intend to transform lives. We are driven by compassion for others and our communities give hope to each individual.'

The mission statement was supported by a vision to be 'a leader in therapeutic recovery' and a set of values. The values were to:

- Provide timely, reliable and targeted recovery services that are judged by their quality, their cost effectiveness and relevance to peoples' needs
- fulfil our obligation of building strong and durable recovery communities, protecting sustainable recovery and meeting our commitments to our partnership working

- attract, develop and retain the interest of our service users by making recovery an enjoyable journey of discovery
- value diversity and the unique contributions of each person, fostering a trusting, open and inclusive environment
- value the passion people have for transformation and we empower our service users to believe in change
- strive for success by pulling together
- treat each other and our differences with a high degree of respect, sharing ideas, failures and successes
- work in innovative ways, network in unexpected ways and make connections across disciplines.

Staff showed a good understanding of the organisation's values and demonstrated them in their work.

Senior management from within the organisation attended the team regularly. Staff told us they knew them personally and that they were approachable.

Good governance

There was a governance structure within the T.H.O.M.A.S organisation that the service linked into. There were governance meetings held at provider level that the service manager attended. Directors were subject to a fit and proper persons test and there was an independent finance committee. All staff had been subject to pre-employment checks and had completed a disclosure and barring service check.

The service monitored performance using the national drug treatment monitoring service and treatment outcome profiles. This was supported by a series of internal audits and health and safety assessments. Blackburn drug and alcohol team were a block purchaser of beds from the service. There was an agreement to provide them with quarterly performance reports. Where commissioning bodies spot purchased beds from the service, performance monitoring was agreed with them in line with their requirements. There was a business development team within the organisation that collated and provided the performance data. Senior management carried out quality visits to the service and reported their findings to the manager and staff.

The service had a series of policies and procedures to support care. These included policies around the management of medications, complaints and compliments, safeguarding and whistleblowing. Policies had been reviewed and were in date. Staff knew how to access the policies if they required them. There was a business continuity policy. This detailed contingency measures in the event of a loss of use of the building or computer and information technology failures.

There were systems to report and review adverse incidents. Learning from incidents and complaints was shared through team meetings and supervision sessions. Staff compliance with mandatory training was recorded and monitored. Staff were provided with regular clinical and managerial supervision. Clinical supervision was provided by an external specialist.

The team manager had access to administrative support and sufficient authority to effectively perform their role. There was a risk register held at provider level which the service could submit items too.

Leadership, morale and staff engagement

Staff were positive about the service manager. They also spoke positively about senior managers within the organisation. They considered managers at all levels to be supportive, approachable and open to suggestions. Staff gave feedback on the service verbally through supervision sessions and in team meetings. Staff told us the service manager had an open door policy if they wished to have a discussion outside of these formats.

Staff morale was positive. Staff showed an enthusiasm for their jobs and a commitment to providing care to clients. There were no bullying or harassment cases within the service. The staff sickness and absence rates were three percent. There had been one substantive staff leave the service between June 2015 and June 2016. Staff described an open and honest culture. They told us they would raise any concerns they had without fear of victimisation.

Commitment to quality improvement and innovation

The service had contributed to a Department of Health and National Treatment Agency project that mapped outcomes of individuals in rehabilitation programmes. The project looked at outcomes in relation to clients' involvement with health and social care services and the impact this had on successful treatment completion.