Scovell Street, Salford

Quality Report

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Salford
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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 and safely maintained. Appropriate health and safety checks had been completed and were up to date. There was a programme of maintenance checks for equipment and facilities. This meant that the environment was safe and comfortable for clients.
- Clients risk was managed. All clients had a comprehensive risk assessment in place. Staff had received safeguarding training and were aware of their role and responsibilities in relation to safeguarding.
- There were sufficient numbers of staff to deliver care. Staff were appropriately skilled and supported. There was a programme of mandatory training and regular supervision. Staff accessed National Vocational Qualifications.
- Care was delivered in line with best practice. Recovery was embedded in the delivery and culture of the service. There were strong links with the local

Summary of findings

recovery community including mutual aid groups. Peer mentors were a visible presence. Care plans were recovery focused. Clients were supported to identify their objectives and the support they needed. Clients were supported to engage with other services.

- Clients received a comprehensive assessment on admission. Care records reflected the findings of the assessment. Clients were involved in the assessment process and completed a self-assessment as part of this process.
- Client feedback on the service was positive. They spoke highly of staff, the treatment they had received and were optimistic about their future.
- Staff morale was good. Staff felt supported by managers and colleagues. There were low absence and sickness rates. Senior managers within the provider organisation were known to staff and visited the service. Staff spoke highly of the local team management. They were considered approachable and open.
- There was a governance structure in place to monitor and support the delivery of care. The service monitored performance through the national drug treatment monitoring system. The service manager contributed to performance reviews for the local treatment network. Processes were in place to report and review adverse incidents and to investigate complaints.

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Background to Scovell Street, Salford

THOMAS Scovell Street is a five-bed residential drug rehabilitation unit based in Salford, Greater Manchester. The service is commissioned by the local NHS trust to provide services as part of the Achieve network.

The service provides residential psychosocial rehabilitation to females. There were five clients in treatment when we inspected. Clients who attend THOMAS Scovell Street have already completed a detoxification programme, which means they are no longer actively using alcohol or illicit substances. The service provides a three to six month rehabilitation programme depending upon the needs and funding of each client. The service follows the 12 step philosophy.

There was a partner service to Scovell Street that was a male only house. This was based at St Boniface Road which was a short walk away. The service manager, team leader and recovery coaches worked across both services.

THOMAS Scovell Street is one of three THOMAS services registered with the Care Quality Commission. It has been registered since March 2015. The service is registered to provide accommodation for persons who require treatment for substance misuse. The previous registered manager had left the service. The service manager was in the process of applying to be the registered manager. There was a nominated individual in place.

The service has not previously been inspected by the Care Quality Commission.

Our inspection team

Our inspection team was led by:

Team Leader: Paul O'Higgins, CQC inspector

The team that inspected the service comprised 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 who is 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 and asked other organisations for information.

During the inspection visit, the inspection team:

Summary of this inspection

- visited THOMAS Scovell Street, looked at the quality of the physical environment and observed how staff were caring for clients
- spoke with five clients
- spoke with the service manager and team manager
- spoke with three other staff members employed by the service provider, including group workers and project workers
- attended and observed two group sessions and a daily meeting for clients
- looked at five care and treatment records, including medicine records, for clients
- reviewed five staff files
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with five clients using the service. Client feedback about the staff and the care they provided was very positive. Clients told us staff were interested in their wellbeing and supported them through their treatment. They described staff as kind and caring and spoke positively about the relationship they had with their key workers.

Clients told us they were involved in decisions about their care. They had been supported to identify their goals and objectives and the support they needed to meet them.

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.
- The service completed health and safety assessments. Fire safety management was in place. There was a programme of maintenance checks for equipment and facilities.
- The service had enough staff to care for the number of clients and their level of need. Vacancy rates, turnover and sickness were all low. Regular bank staff were used to provide cover where required.
- Staff completed mandatory training to support them in their role. All staff had completed their mandatory training. This meant that staff were appropriately trained to deliver care.
- Clients had up to date and comprehensive risk assessments in place. Client risk was being managed.
- Medication was stored and managed safely. Medication administration records were completed and up to date. Staff had access to a medicines management policy and received medicines management training.
- There was a process to report and learn from adverse incidents. 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:

- Care and treatment was delivered in line with best practice. The service delivered treatment in line with the 12-step programme. Clients had access to mutual aid, peer mentors and a range of group and one to one sessions.
- Staff completed a comprehensive assessment. Assessments were used to inform treatment and recovery planning. Clients completed a self-assessment as part of the assessment process.
- Recovery plans evidenced client involvement. They had been regularly reviewed and used an outcome star to measure progress against objectives.
- Staff received regular supervision. All staff had an annual appraisal.

Summary of this inspection

- There were strong links with other organisations. These included other local substance misuse services, the local recovery community and other health services such as GPs.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients were involved in decisions about their care. This was reflected in care records and recovery plans.
- Clients were positive about the staff and staff attitudes. Staff were considered to be caring, knowledgeable and compassionate. Staff displayed a good understanding of the personal circumstances and needs of each client.
- We observed staff treating clients with respect and dignity. Staff were approachable and engaged with clients in a non-judgemental manner.
- Clients were provided with information about the service. They were able to visit the service prior to admission and were given an orientation when they arrived.

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.
- There were clear referral pathways into the service. Referrals were reviewed and assessed in a timely manner. Clients could self-refer into the service.
- Discharge was considered from the point of admission. There was ongoing liaison with the clients recovery co-ordinator to identify client needs and support on discharge.
- The service carried out follow up conversations with clients seven days after their discharge. This helped monitor clients' wellbeing and safety.
- There was a complaints policy and process. Clients we spoke with were aware of how to complain and felt confident to do so.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

Summary of this inspection

- The provider had a set of vision and values. These were on display in the service and discussed during induction and supervision. Staff reflected the services values in the delivery of care.
- The provider had a governance structure in place to support the delivery of care. There was a range of policies and procedures to guide staff.
- The service monitored performance through engagement with the national drug treatment monitoring service. Performance was discussed and reviewed in operational manager meetings.
- Staff morale was good. Staff were positive about the jobs they did. They considered managers to be supportive and approachable.
- There was an open and honest culture. Staff were aware of how to raise concerns and told us that they would feel comfortable doing so.

Detailed findings from this inspection

Mental Health Act responsibilities

The Mental Health Act was not applicable to this service

Mental Capacity Act and Deprivation of Liberty Safeguards

All clients were presumed to have capacity. Capacity to consent was part of the admission criteria and reviewed during the referral and assessment process. Staff knew how to access support if they had concerns over a client's capacity.

The Mental Capacity Act was not part of core training. However staff completed National Vocational Qualification courses that included awareness of capacity and the Mental Capacity Act.

All clients had signed treatment agreements. There were no clients at the service who were subject to Deprivation of Liberty Safeguards.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

THOMAS Scovell Street was located over three floors. There were five single bedrooms. Clients shared toilet and bathing facilities. Clients were informed of this prior to admission. 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.

Health and safety assessments and routine testing was carried out. An annual health and safety assessment was completed. Identified actions had been followed up. A legionella risk assessment had been completed by an external firm. There were regular checks of water samples. Electrical items had been portable appliance tested and were in date. Gas safety and electrical wiring checks had been completed by an approved individual.

There was an identified fire marshal. Fire evacuation drills had been completed and recorded. There were weekly tests of the fire alarm system. Fire-fighting equipment was in date and checked annually. An annual fire safety assessment had been completed. Staff had access to first aid boxes. First aid boxes were checked and refreshed regularly. All staff had completed first aid training.

There were appropriate systems for monitoring and maintaining food hygiene standards. Food was stored appropriately. Kitchen cleaning records were up to date. Staff completed food hygiene training.

There were ligature points in the building and bedrooms. A ligature is a place to which patient's intent on harming themselves might tie something to strangle themselves.

The service did not admit clients who were deemed to be at risk of self-harm. This information was included in eligibility criteria, referral documentation and covered on assessment.

Safe staffing

There was a shared staffing establishment with the male rehabilitation house. The service manager, team leader and two recovery coaches worked across both sites. The Scovell Steet service also employed three recovery assistants who worked specifically at that team. One staff member slept overnight at the service and there was 24 hour access to staff if required. At the time of the inspection, there were no vacancies. Staff turnover in the period August 2015 to August 2016 was 29% (two staff). The staff sickness rate in the same period was 3%.

The service did not use agency staff. The THOMAS organisation employed bank workers who provided floating cover across the sites. Staff sickness or absence was covered by the bank workers. Annual leave was planned in advance to ensure appropriate staffing cover was available at all times. Clients we spoke with told us that staffing levels were appropriate and that they were able to talk to staff when they wanted to. Staff and clients we spoke with told us that the service was never short staffed. Clients we spoke with told us they had never had any planned activities or sessions cancelled due to staff shortages.

Staff had access to a programme of mandatory training. All staff had completed mandatory training. This included safeguarding, first aid, medicines management, information governance, health and safety, fire safety and infection control and blood borne viruses training. Staff also completed National Vocational Qualifications in care.

Assessing and managing risk to clients and staff

Substance misuse services

We reviewed five care records. All of the records had a comprehensive risk assessment in place. Assessments were up to date and included physical and mental health risks, history of substance misuse and previous access to treatment. Risk management plans were captured within client notes and reflected the findings of the risk assessment. We spoke with five clients. All of the clients confirmed that they had a risk assessment and were able to tell us what it included.

Staff received safeguarding training as part of their mandatory training programme. All staff had completed the training at the time of the inspection. Staff we spoke to demonstrated an understanding of safeguarding. They were aware of how to spot signs of abuse and how to raise safeguarding concerns and alerts. There was a safeguarding policy and a nominated safeguarding lead to support staff. There were good relationships with local social services. Where clients were engaged with social services staff liaised with the service, provided updates and reports and if required attended meetings.

There were clients in the service who were on medication. However, the service itself did not prescribe medications. Client medications were stored by the service. There was a locked medication cupboard. The key for the cupboard was kept in a passcode protected key holder. Each client's medication was separated and medications were clearly labelled with client names. The service did not store controlled drugs. There were processes in place for the ordering and return of medications. Documentation such as medication returns sheets were completed. Staff carried out a monthly audit of medication.

Clients self-administered medication. There was a medications policy to support this. Staff received medicines management training as part of their mandatory training. Compliance with training was 100%. Clients taking medication had medication administration record sheets in place. A medication administration record sheet is a legal record of medication administered to an individual. The medication administration record sheets were completed, up to date and clearly stated what medication had been administered.

Track record on safety

Between October 2015 and October 2016 there had been no serious incidents that required investigation.

Reporting incidents and learning from when things go wrong

Staff recorded adverse incidents in client notes and in a separate incident file. Incidents were reviewed by the team lead and service manager. The service had an adverse incident policy in place to support staff. Staff we spoke with were aware of the types of incidents that should be reported and the process for doing so. Incidents were discussed in team meetings. The provider organisation also discussed incidents within its governance structure. This ensured that learning was shared across the THOMAS organisation. There was a process for investigating incidents if this was required.

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 were no recorded incidents which met the duty of candour criteria. Staff demonstrated an open and honest culture within the service. Staff were open with clients about their 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 including current and historic use of substances, physical health, mental health, previous treatment, forensic history, social circumstances and family situation. Clients completed psychological and social self-assessments as part of the assessment process. Clients we spoke with confirmed they were involved in the assessment process and were able to tell us what their assessment included.

We reviewed five care records. All five records had a completed assessment in place. Assessments were up to date. All reviewed care records had recovery plans in place.

Recovery plans reflected the findings of client assessments. They were personalised and captured client views, goals and treatment objectives. Recovery plans were reviewed regularly in key worker sessions and signed by clients.

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

Best practice in treatment and care

THOMAS Scovell Street 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.

Mutual aid groups bring together people with similar issues and experiences in order to provide individuals with help and support to overcome their addiction and to remain substance free. The evidence base shows that clients who engage with mutual aid are more likely to sustain their recovery. The National Institute for Health and Care Excellence recommends that services routinely provide information about mutual aid groups and support clients to attend them clinical guidance 51 'drug misuse in over 16s; psychosocial interventions and clinical guidance 115 alcohol-use disorders: diagnosis, assessment and management of armful drinking and alcohol dependence). THOMAS Scovell Street included mutual aid meetings such as alcoholics anonymous and narcotics anonymous within its weekly activities schedule. Clients were supported to attend by staff and peer mentors.

In line with the 2012 Strang report, commissioned by the National Treatment Agency, there was a focus on recovery within treatment. The service and clients played an active role in the local recovery community. Clients were supported to 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 were linked in with other organisations and were supported to attend appointments and sessions. Group sessions were designed to help clients understand the triggers for their addiction and to develop coping strategies and wider life skills. Clients we spoke with were positive about the group sessions they attended.

Clients who had previously been through a THOMAS rehabilitation programme and were now in the second stage of treatment attended the service to act as peer mentors. 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.

There were 11 peer mentors who were visiting the service. They attended both Scovell Street and the male service at St Boniface Road. Peer mentors engaged with clients, offered support and helped with assignments from group sessions. Clients we spoke with were positive about the involvement of peer mentors and the role they played.

THOMAS Scovell Street did not provide a physical health service. Clients were registered either with their own GP in the area or with the local GP to the service. Clients were supported to attend appointments at the GP, dentist or other health appointments as required. During the inspection, we spoke to clients who had been supported to access health services.

There was a monthly audit of care plans and case management. Discussions around the quality of record keeping and care plans were held in staff 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, living skills, social networks and addictive behaviour. The client scored themselves out of 10 for each domain. The process was repeated in one to one sessions and care reviews. The scores could then be plotted onto the star chart. The star chart provided a visual illustration of the client's progress.

THOMAS submitted treatment data and outcomes to the national drug treatment monitoring system by completing 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 NDTMS on their activities each month. Providers are able to access reports and compare performance against the national picture.

Substance misuse services

Skilled staff to deliver care

The service had a mix of recovery coaches and recovery assistants. Staff had the necessary skills to carry out their duties and deliver care. Some staff members had personal experience of substance misuse. New staff underwent an induction into the service and were given orientation training in line with drug and alcohol national occupational standards. Staff were supported to complete National Vocational Qualification in care qualifications as part of their training.

Staff received regular supervision. Managerial supervision occurred every six to eight weeks. The provider contracted an external clinical psychologist to provide clinical supervision to staff. Supervision records we reviewed showed that supervision was taking place. Staff we spoke with confirmed that they received regular supervision and told us they found it valuable. All staff had received an annual appraisal. There were policies to support managers and staff with the supervision and annual appraisal process.

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

There was a handover between each shift. Information was passed on regarding each client and any incidents or issues from the previous shift. There was a communications book in place used to support this. There was a weekly team meeting for staff to discuss operational issues. There was a programme management meeting fortnightly where each client was reviewed with the recovery coach and team lead. We reviewed minutes of the team meetings and found actions from previous meetings had been followed up.

The service had good working links with external services including the local GP, pharmacy and dental services. There were good relationships with social services and criminal justice services. There were strong links with other substance misuse and support services within the Achieve network. These included local drug and alcohol community teams, family support services and housing services. The service manager attended monthly meetings with other Achieve services to review performance and address any issues. Staff maintained contact with the Achieve recovery co-ordinator throughout treatment. The recovery co-ordinator attended a six weekly review meeting with the client and key worker to review progress and plan ahead. The service had strong links with the local recovery community. This included mutual aid groups, client led recovery forums and support services.

Good practice in applying the MCA

All clients were presumed to have capacity to make decisions about their care and to consent to the treatment programme and its restrictions. This was part of the admission criteria. The Mental Capacity Act was not part of core training. However, staff completed National Vocational Qualification courses that included awareness of capacity and the Mental Capacity Act.

All clients had signed treatment agreements. This included the restrictions within the service, for example access to mobile phones. 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 their GP.

There were no clients at the service subject to Deprivation of Liberty Safeguards.

Equality and human rights

The provider had held briefing sessions for staff on equality issues. There was an equal opportunities and diversity policy in place that covered protected characteristics under the Equality Act 2010 and definitions of discrimination. There was an Equalities and diversity scheme that reflected the provider's response to the Equalities Act 2010.

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 and some clients had recently attended local lesbian, gay, bisexual and transgender groups. These were also advertised within the service.

The service had a list of rules and restrictions that clients were expected to abide by during their stay. These were explained during the referral process and information was included in the welcome pack. Clients were unable to receive visits during the first three weeks of treatment. Phone calls were restricted to three times a week. Restrictions were in place to ensure that the client focused on treatment and were appropriate to the service being provided. Clients signed a code of practice to confirm they understood and accepted the rules as part of their admission.

Substance misuse services

Management of transition arrangements, referral and discharge

The service accepted referrals from NHS and third sector substance misuse services, and criminal justice services including prisons. Clients could also self-refer. As part of their commissioning clients referred to THOMAS Scovell Street had to have a Salford connection unless they had been victims of domestic abuse.

THOMAS Scovell Street was part of the Achieve service. The lead provider for the Achieve service was a local mental health trust. As part of the agreed care pathway all referrals had to be open to the trust and were allocated a recovery coordinator by Achieve. THOMAS Scovell Street worked with the Achieve care co-ordinator to facilitate admission, review care and facilitate discharge. Discharge was discussed from the point of referral. Clients could choose to access second stage rehabilitation services ran by the THOMAS organisation. Clients accessing second stage services had a transition period where they joined groups and activities in second stage services in preparation for their full transfer. When clients were not accessing second stage services staff worked with the Achieve care co-ordinator to facilitate discharge and engage the client with appropriate support services.

Are substance misuse services caring?

Kindness, dignity, respect and support

Clients were positive about the service. They told us that staff were helpful and supportive. We observed positive interaction between staff and clients. Staff were approachable and engaged with individuals in a respectful manner. Clients we spoke with told us that staff were genuine, caring and understanding.

Staff demonstrated a good knowledge and understanding of clients' individual needs. This was also reflected in care records. Staff 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.

The service had a confidentiality policy. The importance of confidentiality was discussed with clients during admission. Staff accessed information governance training as part of the mandatory training programme. This included training around confidentiality.

The involvement of clients in the care they receive

We spoke with five clients. All five clients told us they were involved in their care. They considered themselves to be active participants in decisions. Clients identified their own goals and treatment objectives through the assessment and recovery planning process. We reviewed care records for all five clients and found clear evidence of client involvement. Clients signed care records to show that they agreed with their content. Clients we spoke with were able to tell us what was in their recovery plan, what their objectives and treatment goals were and the support they needed to achieve them.

Clients reviewed their treatment in weekly key worker sessions and completed the outcome star chart to illustrate progress and identify areas to work on. Clients also had six weekly care reviews with their recovery co-ordinator from Achieve.

There was an admission process to inform and orientate clients when they first arrived. Clients referred could also visit the service prior to their admission. There was a welcome pack for new clients which included information on the treatment programme, house rules and how to make a complaint.

Clients were able to give feedback on the service they received. There was a weekly community meeting were clients could feedback their opinions, raise any concerns and make any suggestions. We did not observe a community meeting but clients we spoke with told us they were able to raise any issues they may have. Clients had not been involved in interviewing staff for THOMAS. However, some past clients had sat on interview panels for the Achieve service.

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

Access and discharge

The service had eligibility criteria in place for clients. Referral agencies were aware of the criteria. 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. All referrals were allocated a key worker by the service and a recovery co-ordinator by Achieve.

The service had discharged 11 clients in the previous 12 months. The service carried out a follow up 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 eight (73%) of those clients within seven days of discharge.

The facilities promote recovery, comfort, dignity and confidentiality

The building was pleasant and homely. The service promoted clients taking responsibility and working towards independent living. Clients had responsibility for their own washing and for cleaning their own bedrooms and communal areas. Clients were part of a rota to cook for the house. This included planning menus and shopping for ingredients. Clients ate together in a communal dining area. There was access to snacks and hot and cold drinks outside of meal times. Clients had access to outdoor space.

The premises provided a lounge area which was also used for house meetings; kitchen and laundry facilities; a communal eating area and a staff office. There were additional facilities for group sessions at a recovery café which was within a two minute walk. The café was operated by THOMAS.

Each client had their own bedroom. They were able to personalise their room by displaying photographs and posters. Some of the furniture in the building had been reclaimed and restored by clients as part of a project with local organisations. Information about the local recovery community and recovery services was available to clients.

Meeting the needs of all clients

Due to the layout and nature of the premises, the service was unable to accept clients with limited mobility who were unable to use stairs. Referral agencies were aware of this restriction.

The treatment provided meant that clients needed to be able to contribute to group activities and complete paper-based tasks. Staff supported clients with reading or writing difficulties if this was required. Staff were able to access translation services if this was required. However, if a client did not speak English the service 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.

The service supported clients with their religious and cultural needs. Clients could be supported to attend local places of worship in line with their beliefs.

Listening to and learning from concerns and complaints

There were policies and procedures for managing complaints. Staff and clients we spoke with were aware of the complaints process and how to make a complaint. Information on how to complain was provided to clients. Clients we spoke with told us they felt able to raise complaints and believed they would be dealt with appropriately. There was a procedure to support complaint investigations. Feedback and learning from complaints was discussed in team meetings, supervision and within the provider's governance structure.

The service had received two complaints in the previous 12 months. Both complaints were upheld. There had been no complaints referred to the Parliamentary and Health Service Ombudsman. One of the complaints related to a bank worker who had been covering both Scovell Street and the male service at St Boniface Road. One complaint was specific to Scovell Street. In the same period of time, the service had received seven compliments.

Are substance misuse services well-led?

Vision and values

The THOMAS organisation's mission statement 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 by a set of values. The values were:

- 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 displayed 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 in place within the THOMAS 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 in place. 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 the use of an outcome star, internal audits and health and safety assessments.

Performance was monitored within the provider's operational managers meeting and governance structure. The service manager also attended performance meetings held by Achieve and the lead NHS trust.

There were systems in place 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 morale was positive. Staff worked together well and there was a strong team ethos. Staff we spoke with described a supportive environment .There were no bullying or harassment cases within the service. There had been two substantive staff leave the service in the previous 12 months. Staff sickness and absence rates were low.

There was an open and honest culture. Staff we spoke with told us that managers were approachable and operated an open door policy. Staff were not concerned about raising concerns they may have and told us they felt issues would be managed appropriately. Senior managers within the organisation were known to staff and had visited the service.

Staff were positive about the team leader and service manager. They were considered to be supportive and effective in their roles. Staff were able to give feedback on the service verbally and through supervision and team meetings. Staff told us managers were open to suggestions and encouraged ideas for improvement.

Commitment to quality improvement and innovation

The service was not engaged in any research projects at the time of our inspection. The service participated in local drug and alcohol reviews when requested.