Cranstoun

Quality Report

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

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

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

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

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

Overall summary

We do not currently rate independent standalone substance misuse services.

We found the following areas of good practice:

- The service had a team of committed, trained and experienced staff to care for the clients and their level of need. Staff knew and put into practice the service's values, and knew and had contact with managers at all levels, including the most senior.
- All clients had comprehensive assessments with good risk management and care planning throughout their treatment.
- Staff offered a variety of therapeutic support to clients both in the service and in the community to support their recovery. This support also included working with local wellbeing and social care agencies.
- All clients we spoke with told us about the high levels of care and treatment they received from dedicated staff members.
- Staff we spoke with told us that caseloads were between 50 and 70 per key worker which was very high and produced a lot of administrative duties.

Summary of findings

However these were reviewed regularly by team leaders in monthly supervision sessions.However, we also found the following issues that the service provider needs to improve:

- Risk assessments did not include a plan for unexpected exit from treatment. This meant that we did not see evidence that staff were able to discuss risks with clients, and how to manage them, in case they left treatment early.
- Cranstoun had a policy for managing aggression in the service, however it did not have a policy for visitors under the age of 16. This meant that staff had no guidance to manage visitors under the age of 16. We raised this with the registered manager.

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Background to Cranstoun

Cranstoun leads a partnership of substance misuse support services in Brighton and Hove called Pavilions. Pavilions consists of a range of agencies who all provide support services to people affected by substance misuse issues. The support on offer includes individual and group support, a women only service, opiate substitute prescribing and detoxification, alcohol detoxification, street homeless support, and a community centre café.

The organisation we inspected as part of the Pavilions substance misuse service is called Cranstoun. Cranstoun provides group work, one to one key working sessions, out-reach support, and support to family members and carers of people affected by substance misuse. The service was registered with the Care Quality Commission (CQC) in December 2016 for the treatment of disease, disorder or injury and in May 2017 for diagnostic and screening procedures. The service has a registered manager.

The service we inspected is commissioned by Brighton and Hove City Council.

This is the first time the CQC have inspected Cranstoun as part of the Pavilions. The inspection was completed using our new approach of asking five key questions about the quality of services. CQC do not currently rate substance misuse services.

Our inspection team

The team that inspected the services comprised of a Care Quality Commission lead inspector, Linda Burke, one Care Quality Commission inspector, and one specialist advisor who was a senior nurse with experience in substance misuse.

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.

During the inspection visit, the inspection team:

- looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with three clients
- spoke with the registered manager and two team leaders

Summary of this inspection

- spoke with five other staff members including recovery workers and senior administrative staff employed by the service provider
- looked at seven care and treatment records for clients
- looked at policies, procedures and other documents relating to the running of the service.
- looked at supervision, training, references, appraisals, and disclosure and barring service documentation for staff.

What people who use the service say

Clients we spoke with told us that all staff were kind, professional, caring, and respectful towards them and went out of their way to help clients. Staff helped clients with their housing, physical and mental health support needs. Clients told us that staff dealt with aggression immediately in the service which helped clients feel safe when attending appointments. Clients told us that their key workers helped them understand their drug and alcohol use and always felt welcome as staff knew clients' names when they attended the service.

The service carried out a client survey in 2016-2017 which contained feedback from 161 clients. Clients rated 9.5 out of 10 for feeling safe in the service and 9 out of 10 for feeling empowered by activities and staff.

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:

- All areas of the service were clean, well equipped, well maintained and cleaning records were up to date.
- All staff including peer mentors and volunteers had appropriate references and current disclosure and barring services (DBS) checks in place. DBS checks provide information about the suitability of staff to work with vulnerable adults and children.
- All clients had up to date risk assessments which were reviewed regularly with staff and clients.
- The service had children and adults safeguarding policies which staff were aware of.
- All incidents which occurred in the service were reported and monitored by the management team. Staff told us that team leaders and senior management de-briefed them following incidents.
- The service had trained and experienced staff to deliver support to clients with staffing levels which were agreed with the provider's commissioner.
- Individual staff caseloads across the services were between 50 and 70 per key worker which was very high and produced a lot of administrative duties which were reviewed regularly by team leaders.
- Staff received mandatory training which included equality and diversity, safeguarding, and data protection. The service had a 100% compliance requirement for eight mandatory training subjects. Training completion was at 100% for one out of eight subjects (adult and children safeguarding). The remaining training completion rates were between 78% for Mental Capacity Act training and 95% for health and safety in the workplace.

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

- Cranstoun had a policy for managing aggression in the service, however it did not have a policy for visitors under the age of 16. This meant they had no guidance on how to manage visitors under the age of 16. We raised this with the registered manager.

Summary of this inspection

- Risk assessments did not include a plan for unexpected exit from treatment. This meant that we did not see evidence that staff were able to discuss risks with clients, and how to manage them, in case they left treatment early.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- All clients received a comprehensive assessment when they accessed support at the service which assessed their physical, mental health and social care needs.
- We reviewed seven care records for clients which were all up to date, personalised, recovery oriented, and included clients' strengths to help them achieve their recovery goals.
- Clients had access to psychological therapies as recommended by the National Institute for Health and Care Excellence including brief solution focussed therapy, group work, mutual aid, and motivational interviewing. Support offered also addressed clients' employment, housing, benefits, mental and physical health needs.
- The team included and had access to a range of experienced and qualified substance misuse professionals including support workers, consultants, social workers, nurses, criminal justice professionals, GPs and pharmacists.
- The service had an equality opportunities policy which ensured that anyone using their services, or any employee, volunteer or mentor, was not discriminated against.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- We observed staff being kind, supportive and caring. They were polite and treated clients with dignity and respect.
- There was a large board in the communal office where staff displayed notes and cards from clients saying thank you to staff for their support and care.
- We spoke with three clients who all praised the staff for their dedication, care and professionalism.
- Staff gave clients information on prevention of drug and alcohol related harm throughout their treatment. This was in written and verbal forms. Staff trained clients in overdose management.

Summary of this inspection

- The service offered support and involvement to family members and carers of clients in the form of individual counselling and group support.
- Clients were involved in making decisions about their service. The service held a weekly client forum where clients could feedback on service delivery and suggest improvements.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The service took steps to engage with people who found it difficult or who were reluctant to engage with mental health services. Staff did this by carrying out joint mental health assessments with mental health professionals in the Cranstoun service. This made it easier for clients to have an assessment to identify their mental health support needs and introduce them to mental health professionals in a familiar setting away from mental health services. The service had support in place which removed barriers to vulnerable groups such as pregnant women, homeless people and offenders returning to the community.
- Staff offered clients evening and weekend support for anyone unable to attend during the day due to personal commitments.
- The service had two waiting areas to ensure the reception room was never too busy or stressful for clients.
- The reception and client meeting rooms were based on the ground floor which meant the service was accessible for people requiring disabled access.
- The health promotion team had developed drug and alcohol leaflets and a service leaflet in easy read for use with clients with learning disabilities.
- The three clients we spoke with knew how to make complaints. Complaints processes were outlined on posters displayed around the service.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The service had a clear definition of recovery which was understood and supported by the staff we spoke with. This included delivering person centred care and engagement to clients in the wider community.
- Staff we spoke with told us they were able to raise concerns without fear of victimisation.

Summary of this inspection

- The service attended local Public Health England's drug and alcohol review process meetings for drug related deaths to contribute to local findings and work to improve outcomes for clients.
- Staff took part in innovative research with regard to clients who use new psychoactive substances. They did this by helping to develop training resources to upskill staff in specialist interventions for this client group.
- Staff we spoke with told us there was a high level of stress within the team due to job losses when the contract was implemented in 2015. A small number of job losses had resulted in increased workloads for remaining staff, however team leaders reviewed this regularly in monthly supervision sessions to look at new ways of working to manage the work.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act (MCA) was part of the service's mandatory training programme. Only 78% of staff had completed the training which meant the service did not meet its mandatory training completion target of 100% for this subject. There was an MCA policy which staff could refer to for further guidance. All staff we spoke with explained what they would do if a client lacked capacity. For example, if a client was under the influence of alcohol or drugs, staff would reschedule their appointment so they could engage in treatment when not under the influence of substances.
- Staff got advice regarding MCA issues from managers within the service.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

- All interview and group rooms in the service contained panic alarms to raise alerts if staff required assistance in the event of an emergency. A member of staff with responsibility for safety operations carried out weekly health and safety checks, alarm testing and held regular fire drills. We saw evidence of these in the health and safety logs we reviewed.
- All fire risk assessments and health and safety assessments were up to date. There were fire extinguishers positioned around the service and they displayed up to date checks carried out by an external company. Staff were trained as first aiders and fire wardens and volunteered to be on duty on a daily rota. The rota was confirmed with all team members during the daily morning team briefing. The names of wardens on duty were updated daily on a white board in the communal office area for all staff to see.
- The service had an up to date legionella risk assessment and an accompanying written scheme of control. Staff used this to identify measures required to control potential risks from bacteria. The services had logbooks to monitor these measures which we reviewed.
- All areas of the services were clean and well maintained and cleaning records were up to date.

Safe staffing

- The registered manager told us that staff requirement was based on agreed roles with commissioners to meet delivery of individual sessions and group work.
- Staff sickness for the entire south regional service was at 5%, and staff turnover was 12% ending April 2017. The service did not use any bank or agency staff to deliver client work, however they did have two long-term bank staff in the administration team.
- Caseloads across the services were between 50 and 70 per key worker which they told us was very high due to taking on work from staff who had left the service due to reductions in staffing in 2016. Caseloads included clients who attended groups and one to one sessions and produced a lot of administrative duties which were monitored by team leaders in monthly supervision sessions. Team leaders we spoke with told us they supported staff to develop different ways of working which meant they could manage their administrative duties better. For example, reviewing caseloads and reducing clients' support when their needs reduced, and co-ordinating their care with external agencies as part of their move-on in recovery.
- Activities were reviewed each morning during the team briefing sessions to ensure there were enough staff available to cover scheduled activities for the day ahead. Support sessions were never cancelled due to staff shortages.
- Each team used peer mentors and volunteers to support clients in their recovery. Peer mentors were people who had lived experience of recovery and were drug and alcohol free, however volunteers may not have had a history of substance misuse. All peer mentors and volunteers completed training to enable them to support clients in recovery in groups or individual sessions. These members of the team also helped identify additional activities to support clients in their recovery, such as volunteering or educational opportunities.

Substance misuse services

- All staff including peer mentors and volunteers had appropriate references and current disclosure and barring services (DBS) checks in place. DBS checks provided information to approve people to work with vulnerable adults and children.
- Mandatory training levels across this service were variable. The service had a 100% compliance requirement for eight mandatory training subjects including children and adult safeguarding, health and safety, equality and diversity, and the Mental Capacity Act.**Assessing and managing risk to clients and staff**
- Staff identified risks to clients' health and wellbeing throughout their engagement with the service using comprehensive risk assessments. Client risk was also reviewed at multi-agency information sharing risk panels, client approved liaison with their GPs and mental health professionals, regular key working and group discussions. Client records demonstrated that staff discussed and managed risks with clients and otherprofessionals regarding their children, their physical health and relationships.
- We reviewed seven client risk assessments which were up to date and included thorough risk management plans which detailed steps to be taken by staff and clients to manage clients' safety. Staff routinely reviewed risk assessments every three months or more frequently when new risks were identified. The electronic recording system used by the team sent email reminders to staff to prompt them to carry out their three monthly risk reviews. Risk assessments did not include a plan for unexpected exit from treatment. This meant that we did not see evidence that staff were able to discuss risks with clients, and how to manage them in case they left treatment early. For example, clients may be at risk of overdose if they were less tolerant to drugs if in treatment or at risk of seizures if they stopped drinking alcohol when they were physically dependent on it. Staff told us they followed a three week long re-engagement procedure. This involved telephoning and writing to clients to encourage them to re-engage with support if they left the service without a discussion with a member of the team and before their treatment was completed.
- All staff attended weekly multi-disciplinary meetings (MDTs) where they identified client risks, including where clients were at risk of poor engagement with treatment and support. The MDT could discuss the risks and provide advice.
- Staff discussed clients' risks with them and developed risk management plans with clients in a way which promoted clients' independence. They did this by discussing options and consequences with clients so that they were supported to make choices important to them. For example, when clients failed to attend support sessions but were still collecting their prescribed opiate substitute medication from the pharmacy, staff informed the pharmacist and held the prescription at the service. Staff wrote to clients to invite them in for a face to face consultation to re-engage them with treatment, re-assess their risk around non-engagement and agreed a new care plan. The three clients we spoke with told us they were aware of their risk assessments and discussed risks and how to manage them with their key workers.
- The service had a violence at work policy to help staff manage aggression in the service, however they did not have a policy for visitors under the age of 16. This meant staff did not have guidance on how to manage visitors in that age group. We raised this with the registered manager.
- All staff were aware of the service's children and adults safeguarding policies and were able to explain their responsibilities in informing relevant safeguarding teams of any concerns they had relating to their clients and their children. Staff told us they identified abuse among their client group through assessment, ongoing conversations and observing relationship dynamics with their family members and partners when they visited the service. The team had strong working relationships with the local safeguarding teams and informed us they made 15 adults and seven children safeguarding alerts in the previous six months. All safeguarding referrals and documentation were appropriately documented in the paperwork we reviewed.
- All staff followed the service's lone working policy when working alone in the community. This included recording where they were going, who they were meeting, journey timings in their electronic calendars

which all team members had access to. This meant their whereabouts could be seen at any time by colleagues. All staff had work mobiles to use when out in the community to call when they had safely completed their visits. An agreed emergency procedure was used to alert office staff for assistance when in crisis.

Track record on safety

- Cranstoun reported a total of 23 serious incidents occurring within the last 12 months. All 23 were the type 'apparent/actual/suspected self-inflicted harm' and the most recent occurred on 4 March 2017. Of the 23 serious incidents, 21 of these were categorised as an unexpected death.

Reporting incidents and learning from when things go wrong

- The service had an incident co-ordinator who monitored the reviews of all incidents which were reported and managed via their electronic database, Datix, which we reviewed. All staff were responsible for reporting incidents as they became aware of them. The senior management team investigated all incidents and reviewed them and action plans in their monthly incident review groups. They reported all serious incidents to their local Clinical Commissioning Group on an ongoing basis. Learning was shared across the service at monthly partnership learning meetings and in weekly multi-disciplinary meetings.
- The team de-briefed with team leaders after serious incidents. All support staff attended monthly discussion and support group run by a consultant psychiatrist which had recently been themed 'loss' following a recent number of client deaths the team had experienced.
- Staff at Cranstoun worked together with clients to explain when things went wrong and discussed how to improve their service. For example, the service ran a Saturday morning support session, however on one occasion staff who were scheduled to work that morning did not arrive to open the service to give the peer mentor facilitator access to the building to allow the groups to run. This meant a number of clients had no access to support that day despite having travelled to the service. The registered manager was informed of the incident and immediately investigated what had happened. They identified that staff were not sure they had to work that day and the peer mentor facilitator did not have the duty manager's telephone number. This meant that peer mentor who was also waiting outside the locked service could not contact the duty manager to remedy the situation. The registered manager arranged a meeting with the clients who had turned up, apologised and explained what had happened. The service agreed, to avoid this re-occurring, that the peer mentor facilitator was given all managers' phone numbers and the duty manger rota. The service also agreed that staff scheduled to work on Saturdays were reminded of this in morning team briefings during the preceding week. We observed this reminder taking place when we sat in the morning briefing during our inspection.

Duty of candour

- The duty of candour is a legal requirement, which means providers must be open and transparent with patients about their care and treatment. This includes a duty to be honest with patients when something goes wrong.

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

Assessment of needs and planning of care (including assessment of physical and mental health needs and existence of referral pathways)

- All clients received a comprehensive assessment when they first accessed the service which assessed their physical, mental health and social support needs. Clients' support needs were listed on a recovery star plan which included details such as their financial and housing support needs. A recovery star plan is an outcomes measure diagram which enables clients to measure their own recovery progress, with the help of support workers.
- Staff identified co-existing client mental health support needs during their comprehensive assessment and arranged health appointments for clients to meet these needs as was appropriate.
- The service had established pathways to support clients' physical, mental health and social care needs.

For example, staff referred clients to a range of services offering support for opiate substitute prescribing, mental health assessments, training and employment opportunities in catering and customer service.

- Staff ran relapse management groups and motivation groups to encourage clients to increase their motivation to reach their goals using their personal strengths, such as ability to access mutual aid support when needed.
- Staff monitored and responded to client's changing needs using information captured in their key working sessions and in risk assessments which were reviewed every three months.
- We reviewed seven care plans for clients which were all up to date, personalised, recovery oriented, and included clients' strengths to help them achieve their recovery goals. Staff also worked with clients to identify protective factors which were positive elements to support them in recovery such as hobbies and supportive family members or friends.
- All clients used their recovery plans to prepare for discharge from treatment. This meant they agreed steps with their keyworker, for example to reduce their substance misuse, which would take them closer to discharge from the service.
- All client records were stored securely and electronically so that staff could access them when needed.

Best practice in treatment and care

- Clients had access to psychological therapies as recommended by the National Institute for Health and Care Excellence including brief solution focussed therapy, group work, and motivational interviewing.
- All interventions offered to clients included support regarding their employment, training, housing and benefit needs. There was an electronic screen in the reception area which displayed advertisements about training and education offers available to clients in the community and in the service.
- Staff assessed clients' physical health care needs and referred them to their partner doctors in the service or to clients' own general practitioners (GPs) in the community depending on need.
- Clients' treatment and recovery outcomes were measured by the use of Treatment Effectiveness Profiles (TOPS). Staff used the TOPS tool to measure change and progress in key areas of clients' lives such as substance use, mood, crime, social life and physical health. Staff also measured clients' recovery progress using a recovery star plan. This was an outcomes measure diagram which enabled clients to measure their own recovery progress, with the help of support workers.
- Staff took part in clinical audits in the service. A full case load audit was undertaken in June and July 2016. This reviewed clients' length of time in treatment and clients' recovery status. As a result, senior managers offered suggestions to support staff regarding next steps in supporting clients' towards recovery and improved engagement. A health and safety audit was carried out in October 2016 at the service. This audit covered health and safety information being displayed, training records, accidents and first aid, building risk assessments, health and safety checks, and building maintenance. All audit findings were fed back to the wider team in team meetings and in individual supervision sessions where appropriate.

Skilled staff to deliver care

- The team included and had access to a range of experienced and qualified substance misuse professionals including support workers, consultants, social workers, nurses, criminal justice professionals, GPs and pharmacists.
- All staff received monthly supervision and attended weekly team meetings.
- The service provided specialist training for staff to carry out their roles. For example, motivational interviewing, needle exchange provision, and care planning using the outcome star assessment and care planning tool. One member of staff we spoke with had attended transgender training to help develop the service to meet transgender client support needs. The service had a health promotion team who delivered specialist substance misuse health training workshops as requested, for example blood borne virus and overdose management training. Managers at the service had access to Institute of Leadership and Management Training level 5 to develop them in their roles.

- The registered manager and team leaders addressed staff performance issues in supervision and followed their internal capability procedure with the support of the human resources team where necessary.

Multidisciplinary and inter-agency team work

- Staff attended weekly multi-disciplinary meetings. Partner agencies such as rehabilitation providers, street outreach and women-only services also attended.
- Each morning the service held a briefing meeting where staff handed over important client risk information for the day. We observed this meeting during our inspection, where staff agreed a risk management plan to manage possible risk posed by some clients due to attend that day.
- There were effective working links with local external services such as social workers, primary health care, criminal justice teams, local mutual aid groups, and psychological support teams. Staff consulted these teams to support their clients, and attended each other's meetings as appropriate to share client risk and progress information.

Good practice in applying the Mental Capacity Act (if people currently using the service have capacity, do staff know what to do if the situation changes?)

- Mental Capacity Act (MCA) was part of the service's mandatory training programme. Only 78% of staff had completed the training. This meant the service did not meet its mandatory training completion target of 100% for this subject. There was an MCA policy which staff could refer to for further guidance. All staff we spoke with explained what they would do if they recognised that a client lacked capacity. For example, if a client was under the influence of alcohol or drugs, staff would reschedule their appointment so they could engage in treatment when not under the influence of substances.
- Staff got advice regarding the MCA issues from managers within the service.

Equality and human rights

- Cranstoun operated an equality opportunities policy. This meant that anyone using their services, or any employee, volunteer or mentor, was not discriminated against on the basis of racial, ethnic or national origin, gender, marital status, disability, sexual orientation, age, religious beliefs, HIV/AIDS status, or criminal offences.
- Equality and Diversity training was part of the provider's mandatory training programme. The training completion rate for this subject was 95%. The service engaged people with support needs relating to parenting, drug and alcohol use, and mental health needs.
- The service had an equality and diversity working group that monitored and reviewed how the service met the needs of all the groups within our community, in particular those who were harder to reach such as street homeless clients. The equality and diversity action plan outlined actions arising from the equality and diversity working group and was monitored by the equality and diversity working group. The actions ensured that the service was accessible to and met the needs of people from all backgrounds.**Management of transition arrangements, referral and discharge**
- This service was commissioned by Brighton and Hove City Council. As part of this commissioning agreement they received funding for clients to attend inpatient detoxification and rehabilitation facilities.

Are substance misuse services caring?

Kindness, dignity, respect and support

- We observed staff being kind, supportive and caring. They were polite and treated clients with dignity and respect.
- There was a large board in the communal office where staff displayed notes and cards from clients saying thank you to staff for their support and care.
- We spoke with three clients who all praised the staff for their dedication, care and professionalism.
- We observed staff taking time to explore clients' support needs in a handover session. This conveyed the care they had for clients who used the service. Staff spoke about clients with respect and consideration and took time to resolve issues with them.

The involvement of clients in the care they receive

Substance misuse services

- All clients we spoke with had care plans and developed them with their key workers.
- Information about medicine and treatments was displayed around the service.
- Staff gave clients information on prevention of drug and alcohol related harm throughout their treatment. This was in written and verbal forms. Staff trained clients in overdose management.
- All groups and one to one interventions were strength-based. This meant staff worked with clients to identify what personal strength they had to support themselves, for example motivation to attend support sessions.
- Staff referred clients to other sources of support to live healthier lives such as local wellbeing groups.
- The service offered support and involvement to family members and carers of clients in the form of individual counselling and group support.
- Clients were involved in making decisions about their service. The service held a weekly client forum where clients could feedback on service delivery and suggest improvements. Clients requested a book club, which was operating in the service.
- Clients gave feedback on the care they received using the comments box in the main reception area and in the annual client survey. In the annual client survey 2016-2017, 161 clients rated the statement they felt their opinions mattered in the service as 9 out of 10.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Access and discharge

- The service operated a daily rota of duty workers. This meant that any client attending the service for the first time was offered an assessment on the same day. Staff were also available daily to support clients who phoned in for help or advice.
- The service took steps to engage with people who found it difficult or who were reluctant to engage with mental health services. Staff did this by carrying out joint mental health assessments with mental health professionals in the Cranstoun service. This made it easier for clients to have an assessment to identify their mental health support needs and introduce them to mental health professionals in a familiar setting away from mental health services.
- All staff followed the provider's client re-engagement policy which meant that any client who failed to attend an appointment was contacted to offer a new appointment. If a client continually failed to engage, staff sent a series of letters to encourage clients to engage and offered different ways of re-engaging with treatment. This included being seen at a different safe location, phone support, groups or individual sessions.
- All clients were offered appointment times which suited them. For example, evening and weekend support was available for clients unable to attend during the day due to personal commitments.
- The service had support in place which removed barriers to vulnerable groups such as pregnant women, homeless people and offenders returning to the community. For example, a specialist nurse employed by a partner organisation ran a monthly maternity clinic, staff attended single homeless service meetings in the community, and a weekly Friday afternoon assessment session was available to meet the physical health needs of people being released from prison before the weekend.

The facilities promote recovery, comfort, dignity and confidentiality

- A range of rooms and equipment were available to support the delivery of care and treatment in groups and individual sessions to clients.
- The service had two waiting areas, one in the main reception area and a second next to the clinic and group rooms. This meant staff could escort clients who may be distressed or anxious in the front reception area to a second quieter waiting area in the building. Because of this, the reception area never became too busy due to two waiting areas being available which led to a calm environment for clients and staff.

- Information on local services, clients' rights and responsibilities, complaints procedures and treatment options were displayed in waiting areas and throughout the service.
- A range of activities were offered to clients including recovery groups, art therapy groups, community groups, a book club, and employment sessions.

Meeting the needs of all clients

- The reception and client meeting rooms were based on the ground floor which meant the service was accessible for people requiring disabled access.
- The health promotion team had developed a range of leaflets about drug and alcohol use and a service leaflet in easy read for use with clients with learning disabilities and with low literacy levels. The drug and alcohol leaflets contained diagrams of the human body with easy read messages about where different drugs harmed the body and how they made people feel.
- Staff had to assist with clients' language and communication needs and had recently used a translating service to translate some leaflets into another language for a client in treatment.

Listening to and learning from concerns and complaints

- The three clients we spoke with knew how to make a complaint. Complaints processes were outlined on posters displayed around the service.
- All staff we spoke with knew how to respond to complaints appropriately. We reviewed complaints and saw how staff monitored and reviewed them. Clients fed back to staff that the waiting area in the service was too clinical. Following discussions between staff and clients, client art work was now displayed on the walls.
- Staff received feedback on the outcomes of complaint investigations in weekly team meetings from team leaders.

Are substance misuse services well-led?

Vision and values

- Staff we spoke with were aware of the organisation's values and team objectives were based on these values, for example supporting clients and staff, and performance.
- The service had a clear definition of recovery which was understood and supported by the staff we spoke with. This included delivering person centred care and engagement in the wider community.
- Staff we spoke with were aware of members of the senior management team and told us that the director of operationsvisited quarterly to meet staff.

Good governance

- The service used key performance indicators to monitor the team's performance in areas such as numbers of clients in treatment and numbers of successfully completed treatments. These were set by service commissioners and reviewed at quarterly monitoring meetings. The service also had its own business plan to monitor performance and developed an improvement plan as a result of this. The improvement plan included details of how to engage more clients into treatment from hard to reach communities such as members of the street homeless community.
- The registered manager we spoke with told us they had access to administrative support, had enough authority to carry out their role, and were supported by senior managers.

Leadership, morale and staff engagement

- Staff we spoke with told us they were able to raise concerns without fear of victimisation.
- Staff we spoke with told us that there was a high level of stress within the team due to job losses when the contract was implemented in 2015. A small number of job losses had resulted in increased workloads for all staff which team leaders were reviewing monthly to look at ways of working to manage the work.
- Staff had opportunity to provide feedback into service development. For example, the registered manager suggested that mutual aid groups were run in the service as well as in the community and this was actioned.
- All staff had the ability to submit items to the provider's risk register and we noted that mandatory training was

listed as a risk as not all staff had completed the training in all subjects. The service also had a contingency plan which outlined how the service would run in the community to meet clients' needs if the building was not operational due to a fire, for example.

Commitment to quality improvement and innovation

- The service attended local Public Health England's drug and alcohol review process groups for drug related deaths to contribute to local findings and work to improve outcomes for clients.

Outstanding practice and areas for improvement

Outstanding practice

- The health promotion team had developed a range of leaflets about drug and alcohol use and a service leaflet in easy read for use with clients with learning disabilities and with low literacy levels. The drug and alcohol leaflets contained diagrams of the human body with easy read messages about where different drugs harm the body and how they make people feel.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that all client risk assessments include a plan for unexpected exit from treatment.
- The provider should have a policy for visitors under the age of 16.