The Soke Limited

The Soke

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Good ●
Are services well-led?	Outstanding ☆

Summary of findings

Overall summary

We rated it as outstanding because:

- Staff had developed a truly holistic approach to assessing, planning and delivering care and treatment in collaboration with families and carers. The safe use of innovative and pioneering approaches to care were encouraged and new evidence-based techniques and technologies were used to support the delivery of high-quality care. Staff were actively engaged in clinical audits to evaluate the quality of the care they provided.
- The service provided care and treatment to children and young people, adults of working age, older adults, couples, adults and children with learning disabilities and autistic people.
- The service had access to a wide range of specialists required to meet the needs of the patients through the delivery of multiple therapeutic approaches. Managers ensured that these staff received training, supervision and appraisal. Staff were committed to working collaboratively and used the multidisciplinary team innovatively and efficiently to deliver joined up care, share knowledge and expertise which benefited patients.
- Staff understood the principles underpinning capacity, competence and consent as they apply to children and young people and managed and recorded decisions relating to these well.
- Patients were truly respected and valued as individuals and were empowered as partners in their care, practically and emotionally by an exceptional and distinctive service.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. Staff were highly motivated and inspired to offer care that was kind and promoted patients' dignity. Patients thought that staff went the extra mile and their care and support exceeded their expectations.
- The service was easy to access. People's individual needs and preferences are central to the delivery of tailored services. There are innovative approaches to providing integrated person-centred pathways of care including for people and families with complex needs. The criteria for referral to the service did not exclude patients who would have benefitted from care.
- The service was well led, and the governance and culture ensured that that procedures relating to the work of the service ran smoothly and were used to drive and improve the delivery of high-quality person-centred care. There was compassionate, inclusive and effective leadership at all levels and comprehensive and successful leadership strategies were in place to ensure and sustain delivery and to develop the desired culture. Leaders had a deep understanding of the issues, challenges and priorities in their service.
- The service provided safe care. Clinical premises where patients were seen were safe and clean. The number of patients on individual members of staff was not too high to prevent staff from giving each patient the time they needed. Staff assessed and managed risk well and followed good practice with respect to safeguarding.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Specialist community mental health services for children and young people	Outstanding ☆	We rated well-led as outstanding. The inspection covered the care of both children and young people and adults. A single report has been written to include the services provided to adults and children. Please refer to the main report below for evidence supporting our judgements.
Community-based mental health services for adults of working age	Outstanding ☆	

Summary of findings

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Summary of this inspection

Background to The Soke

The Soke is an independent mental health and wellness centre based in South Kensington / Chelsea. It is a multi-disciplinary centre with practitioners who cover a range of specialities treating conditions including, but not limited to, depression, anxiety, OCD, eating disorders and addictions. The centre treats adults and couples, children, adolescents and families and organisations.

The service employs a range of different clinicians including adult and child consultant psychiatrists, systemic family therapists, chartered and consultant clinical and educational psychologists, Cognitive Behaviour (CBT) and Dialectical Behaviour (DBT) Therapists, psychotherapists and a dietitian.

The Soke describes itself as providing an 'outcome-focused, service-led model' that 'utilises the experience of all our practitioners to ensure that our clients achieve effective, lasting results and benefit from collective experience delivered through a single point of access'.

The Soke opened in October 2020 and registered with the Care Quality Commission in December 2020 to deliver one regulated activity: treatment of disease, disorder and injury. The service has a Nominated Individual and a Registered Manager.

The Soke has never been inspected before.

The Soke Limited, the registered provider, also has a charitable arm, The Soke Foundation, a non-profit organisation that supports non-religious and non-political community mental health initiatives in need of funding assistance. The foundation derives its income through a portion of The Soke's profits and its overheads are underwritten by the trustees.

What people who use the service say

The service gathered feedback from patients using the service and shared this with staff on a monthly basis. In September and October 2021 patients said they felt at ease and at home in the clinic. They said the therapists were kind, understanding, supportive and instrumental in bringing about positive change. The environment was described as calming.

Patients we spoke to told us they were treated kindly and felt involved and informed about their care and treatment. They said the clinic was friendly, accommodating and welcoming.

During our inspection we observed interactions between staff and patients that respected their privacy and dignity. Records showed that patients were involved in their care and treatment plan and setting goals.

How we carried out this inspection

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

- Is it safe?

Summary of this inspection

- 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 Soke.

During the visit, the inspection team:

- Visited the premises, looked at the quality of the environment and observed how staff interacted with patients.
- Spoke to three patients.
- Spoke with ten members of staff including, the nominated individual and registered manager as well as the, client services director (CSD), medical director and registered manager, psychotherapist, clinical psychologists and other therapists.
- Attended and observed a multidisciplinary team meeting
- Looked at eight patient care and treatment records.
- Looked at staff employment record checks.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

The inspection team comprised two inspectors.

Outstanding practice

We found the following outstanding practice:

- The service employed a client services director (CSD) whose role was to ensure the best experience for patients. This role oversaw the suitability of every treatment course and ensured that each patient had an in-house advocate and a singular point of contact throughout their relationship with The Soke.
- Practitioners were contracted by days, not number of client sessions ensuring no individual was incentivised to hold on to patients, that they sought the input of other specialists in the building and they avoided unnecessary prolonging of a treatment pathway.
- The service held daily multidisciplinary team meetings (MDT) that practitioners were expected to attend on their contracted days. This meeting was a forum to discuss risk, safeguarding, share information and ensured patients were given the right care and treatment that safely met their needs.
- Seven out of 10 consulting rooms had a low-lit, relaxation pod attached to them. These could be used by patients for up to 40 minutes after their session or for those who did not want to wait for their appointment in the lounge / reception area. Parents of children attending for treatment could also use the pods. The pods provided a calm, quiet space for people to relax in.
- The pods were used for delivery of Alpha-Stim therapy for those with PTSD, anxiety, depression or insomnia. Alpha-Stim is a NICE approved hand-held device that delivers microcurrents to the brain via small clips attached to the earlobes and is proven to be safe and effective. The pods and Alpha-Stim devices could be booked by patients even outside of appointment times free of charge.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Specialist community mental health services for children and young people	Good	Outstanding	Outstanding	Good	Outstanding	Outstanding
Community-based mental health services for adults of working age	Good	Outstanding	Outstanding	Good	Outstanding	Outstanding
Overall	Good	Outstanding	Outstanding	Good	Outstanding	Outstanding

Specialist community mental health services for children and young people

Outstanding ☆

Safe	Good ●
Effective	Outstanding ☆
Caring	Outstanding ☆
Responsive	Good ●
Well-led	Outstanding ☆

Community-based mental health services for adults of working age

Outstanding ☆

Safe	Good ●
Effective	Outstanding ☆
Caring	Outstanding ☆
Responsive	Good ●
Well-led	Outstanding ☆

Are Community-based mental health services for adults of working age safe?

Good ●

We rated it as good.

Safe and clean environment

All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

All areas were visibly clean, well maintained, well-furnished and fit for purpose. Clinical and public areas were bright and well organised. Toilets were clean and tidy. Fire escapes were clearly signposted on each floor.

Staff followed infection control guidelines, including handwashing. The service had implemented COVID-19 procedures for infection prevention and control (IPC), for staff and visitors. Staff wore appropriate personal protective equipment (PPE). The service had stocks of PPE available for staff and visitors to the clinic and we observed all staff wearing face masks during our visit.

Staff made sure equipment was well maintained, clean and in working order. This included an automated external defibrillator, first aid box, scales and blood pressure monitor.

The reception area was comfortable and clean. It had been designed to support people coming into the clinic to feel calm and relaxed, this included the colour scheme and comfortable seating areas.

The service had an external agency which looked after estates for them as they were in rented premises the landlord was responsible for the upkeep of the building.

Safe staffing

The service had enough staff, who knew the patients and received appropriate training to keep them safe from avoidable harm. The number of patients on the caseload of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.

The service had enough medical staff. There was a medical director who was an adult consultant psychiatrist. The service had also contracted two child and adolescent consultant psychiatrists. This meant staff could get support from a psychiatrist quickly and easily if they needed to. Patients could also be referred for a medical review, if needed.

Practitioners were contracted on a daily rate, delivering a maximum of five sessions per day. This ensured they had the time to write up notes and attend the daily multidisciplinary team meeting. Staff told us there was enough staff to support patients and deliver safe and effective care. For example, they told us they had enough time to update patient records, write letters and attend the MDT meeting.

The service had a head of the clinical board, adult, family and multi-disciplinary therapy and a head of corporate wellness. Since opening, the service has gradually added to their staffing as they became busier. The chief operating officer (COO) told us that at the time of our visit that they delivered around 85 sessions per week with the capacity to deliver 105. When the service reached 90% utilisation, the service would look to recruit more clinicians. At the time of the inspection the service had 21 clinicians.

In addition to clinical staff, the service was committed to ensuring enough administrative cover and had recruited two new members of staff to start in January 2022. This meant that as the clinical side expanded there would continue to be enough administrative support to meet the increased need.

Mandatory training

Staff had completed and kept up to date with their mandatory training.

The mandatory training programme was comprehensive and met the needs of patients and staff. The service had an online e-learning platform that all staff could access. This included mandatory training modules such as complaint handling, equality and diversity, IPC, lone working, safeguarding adults and children and whistleblowing.

Managers monitored mandatory training using a training matrix and alerted staff when they needed to update their training. The online learning platform was also used to record completed training. The training platform produced a report which was discussed at the board meeting. Heads of department reminded staff to complete modules which needed to be updated. At the time of our inspection the overall compliance rate for completion of all mandatory training was 92%. This figure included new staff who had not yet completed all their mandatory training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff followed good personal safety protocols.

The service had a proactive approach to anticipating and managing risks to people who used the service which was embedded and recognised as the responsibility of all staff. Staff were able to discuss risk effectively with people using the service. People who used the services and those close to them were actively involved in managing their own risks.

Staff completed risk assessments for each patient at the start of their treatment and reviewed this regularly, including after any incident. The risk assessment tool had a risk rating of low, medium or high and was updated as and when the risk changed. Risks included suicide, self-harm, self-neglect, treatment, behaviour, sexual behaviour, drugs and alcohol, exploitation, risk of withdrawal, physical health and radicalisation, as appropriate. Clinicians were expected to update this following each session and in consultation with the MDT.

Community-based mental health services for adults of working age

Outstanding ☆

All patient records we looked at had an up to date risk assessment that showed evidence of patient and carer involvement. For example, one young person shared concerns about a family member and with their consent the therapists invited their parents into the clinic to discuss these concerns. Information was also shared with other agencies such as the local authority and GP, where appropriate. For example, the local authority designated officer had been informed when information was disclosed that could potentially place other children at risk.

Staff followed clear personal safety protocols, including for lone working. The clinic had a lone working policy which all staff were expected to read as part of their induction. All staff were expected to complete mandatory lone working training, and compliance with this was 89% at the time of our inspection. The provider had also installed a panic alarm system and new staff made were aware of this as part their induction.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. All staff we spoke to had a good understanding of how to recognise signs of abuse and how to escalate concerns if they thought a child or adult was at risk of harm.

The service had clear and detailed safeguarding policies and procedures in place. Copies of these were available on the shared drive but also within a folder in each clinic room, for ease of access.

Staff kept up to date with their safeguarding training. All staff including administrative staff were expected to complete level 3 mandatory training in safeguarding children and adults. At the time of our inspection only one member of staff was yet to complete this with an overall compliance rate of 96%.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them**.** Safeguarding was a standard agenda item at the MDT, where staff could raise issues of concern. This forum was particularly valuable in supporting staff working with children and families, to share information and seek guidance and support to work through complex situations to ensure safe outcomes.

Patient records showed safeguarding issues were identified quickly and staff made appropriate safeguarding referrals.

The registered manager for the service was the designated safeguarding officer and was trained to level 4 safeguarding adults and children. The service had a safeguarding lead, who also a clinician. This meant there was always someone available for staff to discuss safeguarding issues with.

The service had made safeguarding a priority for quality improvement and had recently introduced a safeguarding panel made up of the designated safeguarding officer, the designated safeguarding lead, appropriate lead consultant psychiatrist (child or adult) and the clinician responsible for the patient's care. The panel would be available for clinicians to discuss individual cases with, where appropriate. This meant the service approach to safeguarding was supportive of clinicians, decision-making was sound and kept patients safe. This panel met formally as and when required.

Staff access to essential information

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

The systems the provider had to manage and share the information that was needed to deliver effective care treatment and support, were coordinated, provided real time information, and supported integrated care for people who used the service.

Patient notes were comprehensive, and all staff could access them easily. The service used an integrated clinical records system for managing patient data and admin tasks. It was used to record all patient information including consent; crisis plans, risk assessments, set treatment goals, generate discharge letters and prescriptions.

Staff could update and access records quickly and easily. This improved the patient experience. For example, patients using both private and NHS health care systems were able to have access to their information immediately following a session as it enabled letters to be sent by password protected email directly from the electronic records system, which could be shared with NHS professionals if needed.

Records were stored securely. The electronic records system required a username and password and practitioners could only access patient records of those they were treating.

Medicines management

The service used systems and processes to safely prescribe medicines. Staff regularly reviewed the effects of medicines on each patient's mental and physical health.

Staff followed systems and processes to prescribe medicines safely. There were policies and procedures for the prescribing of medicines in accordance with national guidance. Medicine administration records and prescriptions were stored securely as these were integrated into the patient record system, which enabled doctors to generate prescriptions that could be printed off or emailed directly to certain pharmacies for dispensing. No medicine was stored on site.

Doctors reviewed patient's medicines regularly and provided advice to patients and carers about their medicines. The electronic records system allowed for letter templates to be set up where conversations were similar. For example, the effect of certain medicines on the unborn foetus and breast feeding. Staff could then access this information quickly and easily for patients.

Staff learned from safety alerts and incidents to improve practice. For example, the psychiatrists received monthly medicines alerts through registration with Medicines and Healthcare products Regulatory Agency (MHRA).

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Doctors we spoke to followed good practice in prescribing and monitoring medicines. For example, if a patient requested an early prescription the reasons for this would be discussed with them and if deemed appropriate, these would be clearly recorded.

Staff reviewed the effects of each patient's medicines on their physical health according to the national institute for health and care excellence (NICE) guidance. Doctors we spoke to told us they also used British Association for Psychopharmacology guidelines because they provided more detail in terms of evidence base. The psychiatrists held peer meetings every six months in addition to their continuing professional development (CPD) groups. These informal discussions around the evidence base for using specific medicines, meant they could share knowledge and expertise.

Compliance with medicines policy and procedure was routinely monitored. For example, the medical director had undertaken an audit in September 2021 to assess the proportion of patients who had their capacity to consent to

treatment document on their electronic record. The results of this were that 100% of patients audited had this information recorded. An audit of controlled drugs (CD) carried out in October 2021 showed 100% compliance rate with recording a patients' consent to treatment, recording the rationale for prescribing a CD and sending a letter outlining the medicine dose.

Track record on safety

The service had a good track record on safety with no serious incidents recorded since it had opened in October 2020.

The service had major incident contingency plans which included relevant actions and contacts should they occur. There were also policies on COVID-19 and health and safety. These documents were available for all staff on the shared drive.

The service carried out regular fire drills

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

There was a genuinely open culture in which all safety concerns raised by staff and people who used the service were highly valued and integral to learning and improvement. All staff were open and transparent, and fully committed to reporting incidents and near misses. Learning was based on a thorough analysis of things that went wrong. All staff were encouraged to participate in learning to improve safety as much as possible, including working with others in the system.

Staff knew what incidents to report and how to report them. The service had an incident management policy which was part of staff induction and was available on the shared drive. Staff raised concerns and reported incidents and near misses in line with the provider's policy. For example, a non-clinical member of staff told us they had received information of concern about a child during a phone call with their parent. They discussed the concerns with the registered manager and completed an incident form following the call.

Staff we spoke to understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. The client experience audit 2021 included evidence that patients received an apology and support. For example, when one patient had difficulty connecting to an online therapy session an apology was given and they were offered a free alternative appointment session.

Although the service had no serious incidents since they opened, incidents and outcomes were discussed with staff in the MDT. Heads of departments also provided feedback on incidents to their team members including any follow up actions. The service had a monthly newsletter circulated to all staff which included learning from experience and safeguarding. For example, in the September 2021 newsletter staff were reminded of the internal referral process and escalating high risk concerns.

Staff met to discuss the feedback and look at improvements to patient care. For example, one person said they could hear a therapy session when using one of the pods. This was immediately raised as an incident and discussed at management meeting. Soundproofed curtains were purchased. This issue was put on the service risk register until the curtains could be installed and mitigated by not placing people in pods when the adjacent therapy room was in use.

Community-based mental health services for adults of working age

Outstanding ☆

There was evidence that changes had been made as a result of feedback. For example, following a patient calling in crisis it was discovered crisis plans were not easy to locate on the electronic records system. The service worked with the system provider to enable easier access to these documents. This meant when a patient needed support quickly staff could access their personalised crisis plan easily.

Are Community-based mental health services for adults of working age effective?

Outstanding ☆

We rated it as outstanding.

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.

The service had a truly holistic approach to assessing, planning and delivering care and treatment to people who use the service. The safe use of innovative and pioneering approaches to care and how it is delivered were actively encouraged. New evidence-based techniques and technologies were used safely to support the delivery of high-quality care.

Staff completed a comprehensive mental health assessment of each patient. All records we looked at showed this had been done at the start of a person's treatment. This included physical health, social, family and mental health history.

Staff developed a comprehensive care plan for each patient that met their mental health needs. The service had recently implemented a new goal-based outcome measure where the patient and clinician decided on goals together at the start of the therapy process. For example, one patient had goals focussed on their relationships, mood and food. This meant patients felt involved throughout the treatment process and that treatment effectiveness could be measured.

Staff regularly reviewed and updated care plans when patients' needs changed. The goal-based system was integrated into the electronic patient record system, which meant patients could review their goals with the clinician easily whenever needed. For example, one patient reviewed their goals with the doctor every sixth session to track progress.

Care plans were personalised, holistic and recovery orientated. All records we looked at showed detailed evidence of patient involvement and carer / parent involvement where the patient was under 18. Patients were consistently asked for their views on what they wanted out of their treatment. This was documented in the record of sessions as well as the goal-based outcome measure document.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Community-based mental health services for adults of working age

Outstanding ☆

All staff were actively engaged in activities to monitor and improve the quality of outcomes. Opportunities to participate in benchmarking and peer review were proactively pursued. Accurate and up-to-date information about effectiveness was shared internally and externally and was understood by staff. This information was used to improve patient outcomes, and improvement was checked and monitored. Outcomes for people who used the service were positive, consistent and regularly exceeded expectations.

Staff provided a range of care and treatment suitable for the patients. The service had a range of different clinicians divided into three teams: adult therapy, family therapy and multidisciplinary therapy each with a head of department. Using a multi-disciplinary approach, the service treated a wide range of different conditions including depression, anxiety, eating disorders, addiction, phobias, mental health and personality disorders.

The clinic contracted clinicians including coaches, counsellors, nutritionists, psychiatrists, psychologists and therapists who offered a range of different approaches including individual, couples, family and group therapy as well as education and seminars. Due to the MDT approach adopted, families could have group as well as individual therapy under one roof.

Staff delivered care in line with best practice and national guidance (from relevant bodies such as NICE). At the time of our visit, the service provided 14 different, evidence-based interventions including attachment, integrative, interpersonal, psychodynamic, schema and systemic family therapies. For example, one clinician told us about a patient with a binge eating disorder being treated with Cognitive Behaviour Therapy enhanced (CBT-E) as it is recognised as one of the most effective treatments for this condition and is delivered through 20 treatment sessions over twenty weeks.

The service also offered Dialectical Behaviour Therapy (DBT) which has proven efficacy in the treatment of personality disorders as well as Eye Movement Desensitisation and Reprocessing (EMDR) for the effective treatment of anxiety, trauma and post-traumatic stress disorder (PTSD). The service also offered life coaching where patients could work toward a specific outcome.

Staff made sure patients had support for their physical health needs, either from their GP or community services. Clinicians liaised closely with GPs who could make referrals into the service and sent a copy of the patient's discharge letter following treatment.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes. The service had used Generalised Anxiety Disorder Assessment (GAD7) and the Depression Test Questionnaire (PHQ9) but were moving to a new system at the time of our visit. The clinical director told us they were keen to avoid patients undertaking therapy with no clearly defined end and decided to approach this by enabling patients to develop clearly identified goals at the start of the process, which could be measured and audited.

The service had recently developed the Goal Attainment Scale (GAS) using measures from the other, evidence-based outcomes scales. For example, the ADHD toll outcome scale, Y-BOC (for OCD), the Berkeley Inventory Scale (for depression) and GAD (for generalised anxiety). The GAS was embedded in the electronic records system and the service planned to develop a dashboard to create a report that could track progress at a macro and micro level.

Following a trial in August 2021, the GAS was now being rolled out across all patients. Patients defined at least three goals at the start of their therapy with their clinicians. These could then be reviewed and reported on. The aim was for all clinicians to be using this by the end of January 2022 and then audited regularly.

Staff used technology to support patients. For example, Alpha-Stim therapy devices were available free to all patients and families of patients with PTSD, anxiety, depression or insomnia. Alpha-Stim is a NICE approved hand-held device that delivers microcurrents to the brain via small clips worn on the earlobes and is proven to be safe and effective. Alpha-Stim devices could be booked by patients even outside of appointment times free of charge. Electronic tablets had also been recently introduced to support patients to give feedback at the end of their treatment.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The service had an audit calendar to track audit activity. They had completed audits in a range of different areas including a ligature risk, incidents and staff satisfaction survey audit.

A recent audit of clinical documentation showed 100% of records had up to date assessments, clinical records that were chronological and written clearly for the patient to understand and had patient consent recorded. Ninety-six per cent of records had an up to date risk assessment. A more detailed risk assessment audit showed 100% of patients had historical and current risks documented and that the risk assessment template had been completed in 85% of cases.

Managers used results from audits to make improvements. For example, an incident and safeguarding audit identified some incomplete information gathering and delays in safeguarding reporting. This was discussed with the senior leadership team and led to the introduction of the safeguarding panel for complex safeguarding cases, which the daily MDT had not been able to address. This meant clinicians received additional support to keep patients safe.

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Since they had opened, the service had worked hard to employ clinicians with a wide range of different backgrounds and experience as their patient base increased. This included clinical and educational psychologists, adult and child psychiatrists, a dietitian and family therapists.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care. The continuing development of the staff's skills, competence and knowledge was recognised as being integral to ensuring high quality care. Staff were proactively encouraged to use their transferable skills and share best practice. The daily MDT meeting was one forum used to discuss complex cases and share expertise. For example, one child seen by the child and adolescent psychiatrist disclosed that they had witnessed domestic violence and following discussion at the MDT, the child and their mother were referred to the family therapist. This meant patients and their families benefited from the integrated approach.

Managers gave each new member of staff a full induction including an induction checklist, which identified tasks to be completed on the first day, first fortnight, month and at three months. Each task was assigned a responsible person and required signing and dating once complete. The induction was comprehensive and included policies and procedures, orientation, systems, health and safety, human resources, vision and values, outcome measures and mandatory and statutory training.

Managers supported staff through regular, constructive appraisals of their work. The service had standardised supervision and appraisal forms. All staff we spoke to had regular supervision. For non-clinical staff this was be monthly.

The clinical staff we spoke to had regular supervision through their head of department every four to six weeks as well as external clinical supervision on a monthly basis that they arranged separately. Peer supervision was offered twice a month to all clinicians. Some clinicians had set up separate sessions to discuss certain therapeutic interventions. For example, three clinicians delivering EMDR therapy had set up a peer supervision group.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. The service held a daily MDT and there was plans to make this twice daily when the opening hours were extended to 8pm. In addition to this, staff were encouraged to attend the monthly 'meet and greet' meetings, which provided opportunities for networking and information sharing. Minutes of both meetings were available to all staff on the shared drive.

The service had a training matrix to track mandatory training and clinicians we spoke to told us they were supported to develop their skills and attend training. The service had introduced protected time for admin workers, one hour per shift, for professional development.

Multidisciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. There was a daily MDT meeting held every morning and clinicians were expected and given time in their working day to attend. As the service had plans to extend appointment times up to 8pm, they told us they would increase MDTs to twice per day to ensure clinicians could always attend one. These meetings included standing agenda items, such as new referrals, risk, safeguarding and complex case discussion.

Staff made sure they shared clear information about patients and any changes in their care, including during transfers of care. We observed discussions around patient care in the MDT including any issues of risk. These discussions were open and supportive, with interdisciplinary treatment options discussed. Clinicians told us they valued these meetings as an opportunity to seek support and guidance from colleagues and this meant patients had better outcomes and issues of risk were managed safely and effectively.

Staff had effective working relationships with other teams in the organisation. The service worked hard to ensure clinicians worked well with each other not only through the daily MDT but also through monthly 'meet and greet' sessions, which clinicians were expected to attend and were used for information sharing and networking. Clinicians told us they enjoyed working for the organisation as they felt supported by colleagues who had shared values. Staff we spoke to described it as a family-like atmosphere.

Staff had effective working relationships with external teams and organisations. Most staff worked one or two days at the clinic, and had strong links with other teams, including in the NHS and private practice. This meant they had built a good network of connections with other organisations. For example, one patient was also seen regularly by an NHS community mental health team and the clinical lead had been able to liaise with them closely to ensure the patient had continuity of care and effective information sharing.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the service policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Community-based mental health services for adults of working age

Outstanding ☆

There was a clear policy on the Mental Capacity Act (MCA), which staff could describe and knew how to access. The service had a combined MCA and Deprivation of Liberty Safeguards policy which all staff were expected to read as part of their induction and was available on the shared drive. This contained useful links to further information for example, the MCA code of practice.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. The documentation audit showed clinicians recorded capacity in 100% of records reviewed.

Staff understood how to support children under 16 wishing to make their own decisions and applied the Gillick competency principles when necessary. Staff knew how to apply the Mental Capacity Act to patients aged 16 and 18 and where to get information and support on this. The service had a consent to treatment policy staff were expected to read as part of their induction and was available on the shared drive.

Are Community-based mental health services for adults of working age caring?

Outstanding ☆

We rated it as outstanding.

Kindness, privacy, dignity, respect, compassion and support

Patients were truly respected and valued as individuals and empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service.

Feedback from patients who used the service and those close to them was overwhelmingly positive about the way staff treated them. Patients reported staff going the extra mile in their care and support that exceeded their expectations. For example, one patient said they never felt rushed and another described talking to their therapist as like talking to a friend. Other patient feedback included patients stating they had never expected to achieve what they had done in therapy.

Staff were discreet, respectful, and responsive when caring for patients. The client services director (CSD) was the first point of contact for everyone using the service and told us her role was to support people in their treatment journey and this included regular contact to ensure they were happy with their treatment. Patients told us all staff treated them kindly and with respect.

Staff gave patients help, emotional support and advice when they needed it.

The service had seven pods which contained a leather chaise lounge, small table and lamp. All patients would have a risk assessment completed before they could use the pods, and each was fitted with a non-weight bearing curtain to offer privacy when in use. These were designed specifically with patient comfort in mind and could be used as a place to reflect and relax following a session. They could also be booked and used between therapy sessions by patients or parents of patients, free of charge. Each pod had been fitted with an alpha-stim device. Patients we spoke to told us they had used the pods and the alpha-stim devices which they had enjoyed as part of the therapeutic process.

Each clinic room had recently been fitted with soundproofed curtains to ensure privacy and confidentiality.

Staff supported patients to understand and manage their own care treatment or condition. All patients we spoke to told us they understood their care and treatment pathway. For example, they said this was guided by what they wanted rather than what the practitioner told them they needed.

Staff directed patients to other services and supported them to access those services if they needed help. The CSD worked hard to ensure there was a range of literature and treatment options available to people who might not be suitable for treatment at the clinic. For example, they had a list of recommended clinicians from other areas as well as charitable organisations that could provide support. In one example, they had been able to support a social worker identify agencies that could support a local family in need of input.

Staff understood and respected the individual needs of each patient. The CSD had worked hard to understand the needs of individuals when they initially contacted the clinic and liaised closely with the clinical team both informally and through the MDTs to ensure patients were matched to the right clinician at the start of their treatment journey. She also checked in with patients regularly to support with any issues arising, where necessary.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients and staff. All staff we spoke to told us the clinic was designed to provide a safe, therapeutic environment for everyone and that if they were concerned about something, they would feel comfortable to raise this with their manager.

Staff followed policies to keep patient information confidential. The service had a secure online portal for confidential patient information. Any other information on paper was scanned into the system by the administration team and the document shredded. All staff received mandatory training in data protection and information security with compliance rates for this at 96% and 92% respectively at the time of our visit. The service also had a confidentiality policy available on the shared drive, which all staff were expected to read during their induction.

Involvement in care

Staff made sure patients and those close to them were active partners in their care planning and risk assessment and actively sought their feedback on the quality of care provided. Staff were fully committed to working in partnership with patients.

Involvement of patients

Staff involved patients and gave them access to their care plans. The patients we spoke to told us they felt involved in their care plans. For example, one patient said their wishes had been understood and respected when it came to discussing treatment options and staff supported them to do research into what they felt would help them. They said they had felt listened to when they had expressed their concerns about being prescribed medicines.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. If a patient had communication difficulties, there were clinicians with specific expertise in working with people with learning disabilities and autistic people. This meant those patients could access therapy that best suited their needs.

Staff involved patients in decisions about the service, when appropriate. For example, the provider had created a client experience log, which recorded issues patients raised, actions taken and ensured the team could learn from and improve their practice. One patient had raised concerns about the limited options for recording gender on the registration documents which the registered manager was working with the providers of the electronic patient records system to address.

Community-based mental health services for adults of working age

Outstanding ☆

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients told us they could give feedback to the CSD who they found approachable and supportive. For example, one patient told us they preferred this option as they did not wish to complete a survey. The service also had a comments box and provided patients with satisfaction surveys. Feedback was discussed at the governance meetings.

Staff informed and involved families and carers appropriately. For example, one patient whose daughter was also seeing a separate clinician told us they felt involved in her care. Clinicians told us that when they saw young people, they were mindful of confidentiality but also balancing this with parents' anxiety and that they worked closely with families to ensure information was shared appropriately and proportionately.

Involvement of families and carers

Staff supported, informed and involved families or carers. One parent told us they were always able to arrange an appointment with their child's therapist and although this was always with her daughter present, she understood why. She said it was helpful to have access to all the clinicians under one service and that they communicated with each other, which meant they had a complete picture and a better service. She told us access to care and treatment was less complicated than it had been in the past.

Records we looked at showed evidence of family involvement. For example, in one case the clinician had a discussion with each parent separately about their child's treatment plan and how they could support this. For another young person, the parents had a meeting with the clinician and the child's mother was copied into all correspondence.

Staff helped families to give feedback on the service. The CSD checked in with all patients and parents of patients, where appropriate, after their second session. This was done either by phone call or email depending on individual preference and she followed up on any issues identified.

Are Community-based mental health services for adults of working age responsive?

Good

We rated it as good.

Access and waiting times

The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff followed up patients who missed appointments.

The service had clear criteria to describe which patients they would offer services. There was a referral process in place which included actions and timescales for following up when patients did not turn up for appointments.

The clinic received referrals from a range of routes including self-referrals and via GPs. Referrals were triaged by the CSD who also chaired the daily MDT. Clinicians were expected to attend the MDT on days they worked, which meant more complex referrals could be discussed and ensured people's needs could be met effectively and safely.

The MDT supported an integrated approach to working with patients. For example, one patient referred following a suicide attempt, had a psychiatric review followed by therapeutic input. In another example, a person being treated for

PTSD was able to access a medical review due to low mood and later, a specialist assessment for Autistic Spectrum Disorder (ASD). This treatment pathway was coordinated successfully through the MDT, which enabled clinicians to share information and identify the appropriate treatment pathway. This whole systems approach was designed to meet the needs of patients better.

The clinical lead told us that when they were unable to safely contain risk, they would not take on a referral but signpost the person somewhere that could. Although the MDT approach allowed clinicians to work with people with slightly higher risk, they recognised where the NHS or other appropriate private services might be more suitable to meet someone's need. For example, some patients with an eating disorder presented with a risk too high to be managed safely by the service.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. It was the role of the CSD to support people who contacted the clinic identify the right treatment pathway for them. When new clinicians started, part of their induction involved meeting with the CSD and discussing their areas of clinical expertise. This then enabled her to be able to match patients effectively with the right therapist. She would also contact people who did not attend appointments to follow up and offer support.

Patients had some flexibility and choice in the appointment times available. Patients we spoke to told us they could usually get an appointment at a time that suited them. The registered manager said the clinic was planning to extend their opening hours until 8pm to be able to offer a wider range of appointment times to people.

Staff worked hard to avoid cancelling appointments and when they did patients were given clear explanations and offered new appointments as soon as possible. For example, clinicians were required to give advanced notice of any leave to ensure that cover could be arranged, and patients offered an appointment with another clinician, if appropriate.

Appointments ran on time and staff informed patients when they did not. Patients we spoke to said they had no difficulties with appointments running on time. Although there had been some difficulties with online appointments this was due to system error and was addressed quickly through the client feedback system.

The service used systems to help them monitor waiting lists/support patients. The CSD took the lead in monitoring appointments which could be offered weekly or fortnightly. Appointments slots were integrated into the patient record system. This meant clinicians could complete patient discharges and book patients in.

The facilities promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care. The clinic had been designed to support wellbeing, including the pods and the reception area which was designed like a lounge and had a range of comfortable chairs and settees for people to use whilst waiting for their appointment.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service supported and made adjustments for people with disabilities, communication needs or other specific needs. The clinic had been designed to ensure accessibility. For example, there was a clinic room on the ground floor, for people with physical disabilities to access. There was also a ramp available for use for wheelchair users, a disabled access toilet and all doorframes were wide enough to fit wheelchairs.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. All the patients we spoke to told us they knew how to make a complaint should they want to, and that this information had been made available to them either on the clinic's website or through the CSD.

The service was able to work with people with communication difficulties. For example, some clinicians had specific training and expertise in working with children and adults with learning disabilities or autistic people. Several clinicians were multi-lingual and could deliver therapy in languages including Farsi, Flemish, French, Italian, Russian, Spanish and Swedish.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

The service was registered with the Independent Sector Complaints and Adjudication Service (ISCAS) which is a volunteer subscriber scheme for independent healthcare providers that provides a complaints management framework, complaints handling training and an independent review process with independent adjudication procedures.

Patients, relatives and carers knew how to complain or raise concerns. Patients told us the CSD checked in with them following their second session to address any concerns. They told us they would feel comfortable to raise any issues if they needed to.

Staff understood the policy on complaints and knew how to handle them. All staff we spoke to understood how to support someone making a complaint. Staff were expected to undertake training in complaints handling as part of their induction and at the time of our visit compliance with this was at 96%.

Managers investigated complaints thoroughly and identified themes. Patients and their families were involved in these investigations. The service audited patient experiences and this process included an immediate and organisational response. For example, expanding and developing the functionality of the patient record system to include the ability to make video calls and input appointment times in response to patient concerns about appointment accessibility. This meant appointments were less likely to start late or be missed.

Patients received feedback from managers after the investigation into their complaint. For example, the client experience audit we reviewed showed patients had been contacted by the registered manager to discuss their complaint and follow up on any necessary actions. This meant patients were satisfied with the informal resolution and no further action was necessary.

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, the service was building capacity by ensuring new clinicians were contracted to provide appointments up until 8pm in response to patient feedback.

Community-based mental health services for adults of working age

Outstanding ☆

The service used compliments to learn, celebrate success and improve the quality of care. For example, the staff newsletter contained positive patient feedback. This included a 'milestones' section highlighting the personal achievements of staff.

Are Community-based mental health services for adults of working age well-led?

Outstanding ☆

We rated it as outstanding.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

There was compassionate, inclusive and effective leadership at all levels. Leaders demonstrated high levels of experience, capacity and capability needed to deliver excellent and sustainable care. Comprehensive and successful leadership strategies were in place to ensure and sustain delivery and develop the desired culture. Leaders had a deep understanding of the issues and challenges and priorities in their service, and beyond.

The chief executive officer (CEO), chief operating officer (COO) and registered manager (RM) were visible in the clinic, speaking to patients and staff. The RM attended the MDT meeting which meant she had a solid awareness of the patient group, current risks and was available to provide safeguarding advice and support. The leadership team had worked hard to support and develop good relationships between the MDT as most clinicians worked one or two days per week. This was supported by the 'meet and greet' monthly meetings as well as the flat daily rate clinicians were paid which meant they were expected and had time to attend MDTs on the days that they worked.

Staff spoke positively about the leadership team and said they were approachable and supportive. The staff we spoke to told us they could speak up and felt listened to. Another member of staff said they did not notice any hierarchy with the leadership team, that you could always speak to them and they were very friendly. Staff said they looked forward to coming to work and felt valued in their role.

The RM and head of family therapy shared leadership responsibility for safeguarding including responsibility for working with partner agencies, providing information to and support for staff to ensure issues were identified quickly and kept patients safe from harm. Clinicians could seek safeguarding support and advice through the MDT and the recently introduced safeguarding panel.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

The service strategy and supporting objectives and plans were challenging and innovative, whilst remaining achievable. Strategies and plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership. There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans.

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all the relevant stakeholders. The vision and values were focussed on generosity and collaboration; for patients, stakeholders

and staff. The organisation considered its purpose in addition to its business aims and had established The Soke Foundation, a non-profit organisation with the aim of supporting community mental health initiatives that could benefit from either financial or in-kind assistance. A portion of the clinic's profits were donated to the foundation and were committed to supporting non-religious, non-politically affiliated initiatives that worked toward improved mental health. The organisation was committed to donating a percentage of the annual profits when the organisation began to go into profit.

All new staff were provided with a brand 'bible' which clearly set out the provider's identity in order to support the effective communication of its vision and mission. The provider provided integrated care and encouraged and fostered association between clinicians to provide holistic patient care. The brand 'bible' set out the provider's current objectives and long-term goals.

All staff we spoke to were clear about the provider's vision, values and strategy and worked hard to maintain this. They told us coming into work was something they enjoyed doing and that they felt part of something special.

The service had plans to expand and this included Soke Performance and Soke Education in addition to two new centres. The first of the new centres opening was a children and families centre targeting the 0-14 age group. Work had started on identifying suitable premises and the aim was to be fully operational in 2022.

Soke Performance and Soke Education was created to separate the service's school and corporate clients from their primary work with individuals and families. This had started by embedding a child and adolescent psychotherapist in a local, independent school. This clinician was to be contracted by and receive supervision from The Soke.

Culture

Staff felt respected, supported and valued. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Leaders had an inspiring shared purpose and strove to motivate staff to succeed. There were high levels of satisfaction across all staff. There was a strong organisational commitment and effective action towards ensuring that there was equality and inclusion across the workforce. Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff at all levels were actively encouraged to speak up and raise concerns, and all policies and procedures positively supported this process.

There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences.

All staff we spoke to were extremely positive about the culture telling us they looked forward to coming to work and described it as a family atmosphere. The organisation had worked hard to focus on a developing their culture in line with its vision and values. For example, the CEO and COO had begun work with an external consultant to develop the PACT Principle model (an acronym for purpose, authenticity, communication and trust) for organisational culture.

During our visit we noted the words, 'be generous' had been written on the whiteboard in the basement in the staff lunchroom. The September 2021 newsletter informed staff that this single, short phrase was intended to demonstrate the organisation's values with the ultimate aim of being the representative characteristic experienced by both staff, patients and the wider community.

The service had a whistleblowing policy which all staff read as part of their induction and was available on the shared drive. At the most recent clinical board meeting a decision was taken to appoint a 'Freedom to Speak Up' champion by inviting members of the team to volunteer for this role whose responsibility it would be to feedback on matters to the clinical board.

The service had recently signed up to an employee assistance programme that enabled staff to access confidential external support if they needed it. This included an application offering bespoke wellbeing features, a health and wellbeing portal, individual counselling, occupational health, family advice line and 24 hours a day, seven days a week critical incident telephone support so that staff could access support confidentially when needed.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Governance arrangements were proactively reviewed and reflected best practice. A systematic approach was taken to working with other organisations to improve care outcomes. Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

All staff could access all clinical governance meeting minutes, the incident log and risk register on the shared drive. Staff were able to describe the main risks to the service and learning was shared through team meetings and monthly staff newsletters.

The provider had clear governance processes in place including monthly board, clinical board and leadership team meetings. The clinical board meeting followed an agenda divided into the five Key Lines of Enquiry (KLOE) used by CQC: safe, effective, caring, responsive and well led as well as the service brand values of quality, collaboration and emotional intelligence. This meeting was attended by all heads of departments who disseminated and fed back information to their respective teams.

The monthly board meeting included a review of operational performance, clinical governance, client experience, service development, HR and the corporate risk register. The leadership team included a review of clinical quality and effectiveness, clinical risk register, operational issues including safeguarding and incidents. There was also a weekly operations team meeting which included the RM, CSD and administration team. This meeting discussed finance, practitioner updates, staff availability and capacity, the client journey, satisfaction surveys and administration.

The overall governance and board structure was scheduled to be reviewed in January 2022 to adapt to the expansion of the service including the opening of the new centre to ensure there was a governance structure at each site as well as an organisation as whole.

Management of risk, issues and performance

Staff had access to the information they needed to provide safe and effective care and used that information to good effect.

There was a demonstrated commitment to best practice performance and risk management systems and processes. The organisation reviewed how they functioned and ensured that staff at all levels had the skills and knowledge to use those systems and processes effectively. Problems were identified and addressed quickly and openly.

The service had COVID-19, clinical and corporate risk registers which were discussed and reviewed at clinical board and leadership team meetings. Clear mitigation action plans were in place for each documented risk and a member of the board designated owner for each item. This information was reported to the board through the monthly board meeting and ownership of the registers overseen by the clinical director.

Managers monitored performance indicators including serious incidents and outcome measures. Audits were reported on a monthly basis with recommendations to address any issues identified. Performance indicators were discussed at the monthly board meetings to monitor progress and identify any barriers to mitigating issues identified.

All staff could access the incident log and the risk register on the shared drive. Staff were able to describe the main risks to the service and learning was shared through team meetings, internal newsletter and the MDT.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data and notifications were consistently submitted to external organisations as required.

The service invested in innovative and best practice information systems and processes. The information used in reporting, performance management and delivering quality care was accurate, valid, reliable, timely and relevant. There was a demonstrated commitment at all levels to sharing data and information proactively to drive and support internal decision making as well as system-wide working and improvement. The service had recently contracted a data analyst to create an integrated dashboard with electronic patient records system to develop governance processes further.

The service had recently completed an audit of the goal attainment scale. Fifty-six patient records were reviewed and showed that of goals scored, 65% achieved better or better than expected results. This increased to 92% when they included partially met goals. No patients reported leaving worse than before treatment regardless of whether they completed the full treatment plan.

The service had a comprehensive audit programme, which involved members of the MDT taking responsibility for specific areas. Audit outcomes were fed into a monthly reports, which included learning, actions and recommendations.

Audit data including the quarterly reports was available for staff to access on the shared drive. Heads of departments discussed performance and learning in team meetings and it was also shared via email and staff monthly newsletters

The RM was responsible for submitting notifications to external bodies and did so in a timely manner. This information was recorded on the incident log. Data was also shared through reports and in person meetings with the board of trustees.

We reviewed minutes of board, clinical board, management and weekly operational meetings and found there was clear recording of information, updates and actions.

Community-based mental health services for adults of working age

Outstanding ☆

Engagement

The Soke Foundation is the non-profit arm and financial beneficiary of The Soke Limited. It derived its income through a portion of the Soke's profits and the overheads are underwritten by the trustees. Its aim is to support the work of local organisations that have developed effective solutions for the mental needs of their communities and it supports non-religious and non-politically affiliated initiatives working to improve mental health of vulnerable people and those unable to seek help due to financial or other circumstances beyond their control.

At the start of 2021 the service offered free weekly online support groups for NHS staff at a local hospital for eight weeks. This was a confidential forum designed to support staff emotional and psychological wellbeing and were conducted under the supervision of experienced clinicians.

Learning, continuous improvement and innovation

There was a systematic approach to improvement which was seen as the way to deal with performance and for the organisation to learn. Improvement methods and skills were available and used across the organisation, and staff were empowered to lead and deliver change.

In October 2021 the service established an innovation committee. The purpose of this group was to lead on the service and product development; strategic partnership and academic research. Staff were invited to submit ideas via an innovation application form for approval by the commercial and operations team as well as the clinical board.

The service had a complaints and incident reporting system processes that supported continuous learning and improvement. This included staff de-briefs and incident reviews.

The service had systems to make sure learning was shared with all staff groups. Staff told us they were updated following incidents and complaints through their team meetings and MDTs.

The service was committed to quality improvement (QI) and set QI objectives for each coming year. For example, the development of GAS to audit and measure patient outcomes with the aim of improving patient experience.