

Newbridge Care Systems Limited

Schoen Clinic Chelsea

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

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

Overall summary

We rated it as good because:



- The service provided safe care. The premises where patients were seen were safe and clean. There were sufficient staff of different disciplines to ensure patients, young people and families received the time they needed. Staff managed risk well.
- Staff completed a comprehensive assessment of all patients and young people. The physical health of young people was closely monitored during their time in the programme. Staff engaged in clinical audit to evaluate the quality of care they provided.
- Staff provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. In the anxiety and mood day programme patients were offered a range of evidence based therapeutic groups alongside individual therapeutic input. Therapeutic groups provided in the eating disorders day programme included body image group, self-esteem group, creative arts, parents group and a MANTRA group adapted for young people from the Maudsley Model of Anorexia Treatment for Adults, an evidence-based approach.
- The teams included or had access to the full range of specialists required to meet the needs of patients and young people under their care. Managers ensured that these staff received supervision and appraisal and opportunities for professional development. Staff worked well together as a multidisciplinary team and relevant services outside the organisation.
- Staff treated patients and young people with compassion and kindness and understood the individual needs of patients and young people. They actively involved patients and young people in decisions. Young people were actively involved in care and treatment.
- Every person we spoke to was overwhelmingly positive about the care they had received or were receiving at the service. All the patients, young people and carers/parents praised the staff and told us how they had helped put them at ease.
- Staff supported family members throughout their loved one's treatment. All the family members that we spoke to said that the level of support provided by staff was greatly appreciated and they felt involved in their loved one's care.
- The service was easy to access. Staff planned and managed discharge well and had alternative pathways for people whose needs it could not meet.
- Staff offered flexible appointments to patients, young people and family members. Staff would adapt the timing of appointments and therapies to suit individual's work and school commitments.
- The service was well led, and the governance processes mostly ensured that its procedures ran smoothly.

However:

- Staff did not always complete a full record to demonstrate the reasons why they had not made referrals to the local authority to keep individuals safe from abuse and improper treatment.
- Care plans of patients on the anxiety and mood pathway did not always demonstrate patient involvement and some lacked sufficient detail.
- Care records of adult patients did not always clearly explain how patient risks were being managed.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Specialist eating disorder services	Good 	
Community-based mental health services for adults of working age	Good 	

Summary of findings

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Summary of this inspection

Background to Schoen Clinic Chelsea

Schoen Clinic Chelsea was registered in March 2019, this was the first inspection of Schoen Clinic Chelsea.

Schoen Clinic Chelsea is a mental health day care and outpatient treatment service. The service operates two treatment pathways:

Treatments for adults with anxiety and mood disorders (A&M)

An eating disorder service for children and young people (ED)

The service operates five days a week, including evenings, and offers patients and young people and families the options of face to face treatment or an online therapy programme. The clinic is in a purpose built building there is a reception area, six therapy rooms, three group therapy rooms, a lounge, relaxation area, a treatment room and kitchen/dining room.

Schoen Clinic Chelsea is registered to provide the following regulated activities:

Treatment of disease, disorder or injury

Diagnostic and screening procedures.

Our inspection team

The team that inspected this service comprised of three CQC inspectors, one CQC inspection manager and one specialist advisor who had experience of working within eating disorder services.

What people who use the service say

Every person we spoke to was overwhelmingly positive about the care they had received or were receiving at the service. All the patients, young people and carers/parents praised the staff and told us how they had helped put them at ease and made them feel 'normal'. One patient said that the kindness they received from everyone from the reception staff to the consultant made them feel accepted for who they are. Multiple patients told us that the service had changed their lives for the better.

Young people's parents also praised the service highly. Parents said that the service was incredibly supportive and provided a clear programme ahead of them. All the parents we spoke to felt suitably informed and had regular appointments with their child's key worker. One parent said, "the service made me feel like my daughter is the only one on the programme". We received no negative feedback from parents or young people in relation to the service.

How we carried out this inspection

During this inspection, the inspection team:

Summary of this inspection

- visited the service and observed the environment and how staff were caring for patients and young people
- spoke with the registered manager
- spoke with ten members of staff including, consultant psychiatrists, clinical psychologist, private enquiries manager, nurses and key therapists
- spoke with five people using the service
- spoke with four family members of young people using the service
- reviewed eight patient care and treatment records
- observed a business meeting with the clinical director and senior managers from the provider
- observed two therapeutic groups
- looked at policies, procedures and other documents relating to the running of the service.

You can find information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

Areas for improvement

Community-based mental health services for adults of working age

Action the service SHOULD take to improve:

- The provider should ensure that safeguarding decisions are documented and the local authority are suitably informed.
- The service should ensure the all care plans for adults are person-centred and personalised and care records are consistently high quality.
- The service should ensure that all risk assessments for adult patients are detailed and record clearly how identified risks are being managed.






Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Specialist eating disorder services	Good	Good	Good	Good	Good	Good
Community-based mental health services for adults of working age	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Specialist eating disorder services

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

Are Specialist eating disorder services safe?

Good 

We rated it as good.

Safe and clean environments

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

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. Staff had recently completed risk assessments in relation to fire, health and safety, ligatures and infection control.

All interview rooms had alarms and staff available to respond.

The clinic/treatment room was well equipped with the necessary equipment to carry out physical examinations and measure young people's weight and height. The examination couch was visibly clean and free from damage. All areas were clean, well maintained, well-furnished and fit for purpose.

Staff maintained equipment and kept it clean. Staff cleaned equipment after use. The service ensured equipment and medical devices were serviced and calibrated in line with the manufacturer's instructions. Records showed that weighing scales and height measures were checked monthly. The electrocardiogram machine had been serviced and repaired in February 2022.

Staff made sure cleaning records were up-to-date and the premises were clean. Domestic staff attended the service on Tuesdays, Thursday and Fridays. The service manager felt this arrangement was working well. The training kitchen was clean and well organised. Sharps were locked away in a safe, the fridge temperature was regularly checked and food was labelled with opening and use by dates.

Staff followed infection control guidelines, including handwashing. At the time of inspection all staff were observed to be wearing appropriate personal protective equipment (PPE). PPE was readily available in the reception area for young people, their families and staff to access. Hand sanitizer stations were located throughout the building. Staff maintained

Specialist eating disorder services

specific changes designed to minimise COVID-19 transmission. Cleaning requirements had increased since the pandemic. Chairs and desks in the service were set apart. Perspex screens had also been introduced to help separate desk space. Visitors were asked to complete a short form in relation to COVID-19 related information upon entry to the service. The service had recently had an independent infection prevention audit carried out. Overall, the service had a compliance rate of 77%. The service had produced an action plan to follow up the areas of non-compliance.

Staff checked the contents of the emergency equipment bag every month. Records showed that planned checks had been completed over the last six months. Staff checked the automated external defibrillator every week and ensured that the defibrillator pads were within the expiry date.

Safe staffing

The service had enough staff, who knew the young people and received appropriate training to keep them safe from avoidable harm. The number of young people using the service was not too high to prevent staff from giving each young person the time they needed.

The service had enough staff of different disciplines to keep young people safe. Young people that we spoke with said that there were enough staff to meet their needs. At the time of inspection, the service had 2.9 FTE vacancies, most of these vacancies were new posts created in the children and young people pathway. Interviews for these positions had been booked.

Therapy staff were made up of a combination of full time and part time workers.

Senior staff told us they were able to recruit staff based on the needs of young people. The clinic director told us that recruitment of specialist clinicians had been challenging. In response to this they had decided to recruit more junior staff and to develop them internally. For example, the service had recently recruited a therapy assistant in their second year of training.

The service did not use any bank or agency staff.

The consultant psychiatrist noted that relying on a sessional dietitian for the eating disorders service had not been ideal. But a substantive dietitian was due to start in the service in the next week.

Managers supported staff who needed time off for ill health and sickness levels were low. Managers were able to plan to cover staff sickness and absence.

The children and young persons' pathway had enough medical staff. There were two part time consultant psychiatrists in post at the time of inspection. The parents and carers of young people said that they could contact a consultant as and when required.

The service could get support from a psychiatrist quickly when they needed to.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. Training compliance ranged from 80% to 100% in the service.

Specialist eating disorder services

The mandatory training programme was comprehensive and met the needs of young people and staff. The training included, fire safety, resuscitation, safeguarding, mental health awareness and mental capacity training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers would discuss training compliance during regular supervision.

Assessing and managing risk to young people and staff

Staff assessed and managed risks to young people and themselves. They responded promptly to sudden deterioration in a young person's health. When necessary staff worked with children and young people and their families and carers to develop crisis plans. Staff followed good personal safety protocols.

Assessment of patient risk

Staff had a clear understanding of risk and gave examples of when they had escalated young people who were assessed as high risk, including young people who were referred to a hospital emergency department as a result of very low weight.

The private enquiries manager carried out an initial screening of referrals to see whether they were suitable for and could benefit from the service. They explained the service that was offered to adults and to young people, explained the inclusion and exclusion criteria and signposted referrers to other more appropriate services when needed. The private enquiries manager had received training to determine whether the service could potentially meet the prospective patient's needs. If they had any doubts or were unsure, they consulted with a clinician. They always checked whether the young people had a clinician such as a GP or consultant involved in their care already. Following the initial triage young people were allocated to a consultant psychiatrist for a comprehensive assessment of their needs and risks.

The consultant psychiatrist that we spoke with was clear the service was only provided to young people who were considered low risk.

Risk assessments were completed by the assigned key worker in their first key work session with the young person. The risk assessment was reviewed every four weeks or more frequently if new risks arose. Risk assessments were reviewed again on discharge from the programme.

All young people received a comprehensive physical health assessment. All three records we reviewed showed each young person had an ECG, blood test and vital signs recorded as part of the admission process.

Alarms were present in all consultation rooms.

Management of patient risk

Staff responded promptly to any changes in risks to young people and sudden deterioration in a young person's health. Staff discussed patient risk daily in the morning handover meeting. For example, if staff were concerned about a young person then they would refer them to an inpatient service. All young people were also discussed during a weekly MDT meeting. These meetings were attended by the pathway consultants, dietitian and psychologists. The notes from these meetings were added to each young person's progress notes.

Specialist eating disorder services

Staff monitored the physical health of young people in the service. All three patients whose records we reviewed were having their physical health monitored on a weekly basis.

Adults and children and young people used services in the building. The service kept the two age groups apart to maintain safety. Staff escorted children and young people around the building at all times to prevent any contact with adults.

Safeguarding

Staff understood how to protect young people 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 and staff kept up-to-date with their safeguarding training. The service had four mandatory training modules about safeguarding children and adults. Compliance ranged from 80% to 100% for these modules.

Staff we spoke with had a good understanding of safeguarding. Staff knew how to recognise concerns regarding potential abuse of vulnerable adults and children. They provided clear examples of safeguarding issues identified in the service and how they had been reported to the local authority safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff knew who the safeguarding lead for the service was and staff had contact details for staff at the local authority.

Safeguarding concerns were reviewed during team meetings. For example, in the January 2022 team meeting a young person was discussed with a possible safeguarding concern, the team agreed that it was not a safeguarding concern. This decision was documented on the incident report.

Staff access to essential information

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

Care notes were comprehensive, and all staff could access them easily. Young people's progress notes were detailed and contained input from across the MDT.

The records system was adopted from a physical health service under the same provider. Staff told us that this system had its limitations and was not best suited for mental health work. The clinic director was keen to adapt the current system so that staff could navigate and complete records more easily.

Records were stored securely. All computer systems were accessed by individual usernames and passwords.

Medicines management

The systems and arrangements for managing medicines and equipment minimised risks. The service kept prescription stationery securely and monitored its use. Documents for prescribing medicines were kept in a locked filing cabinet. Prescriptions could be collected by carers/parents or would be delivered via specialist courier.

Specialist eating disorder services

Medical staff prescribed medicines to young people and gave advice on medicines in line with legal requirements and current national guidance.

No medicines were stored on site.

Track record on safety

The service had a good track record on safety.

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 young people honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with provider policy. Incidents were reviewed during team meetings. For example, between October and December 2021 there were no serious incidents but there were 12 lower level incidents. These incidents were discussed in the January governance and quality meeting. During these meetings staff would be reminded to report all incidents using the electronic incident reporting system.

Staff understood the duty of candour. They were open and transparent and gave young people and families a full explanation if and when things went wrong. For example, in the adult service, staff apologised to a patient when the subject line of a confidential email included the patients full name.

Managers told us they would debrief and support staff after any serious incident. Due to the service seeing low risk young people this had not been required by the time of the inspection.

Managers investigated incidents thoroughly. Young people and their families were involved in these investigations.

There was evidence that changes had been made as a result of feedback. For example, there had been a few incidents related to confidential information being wrongly shared. The learning from this incident was that all staff should receive further training about information governance. All staff were reminded of the importance of checking information in emails before sending during a recent governance and quality meeting.

Are Specialist eating disorder services effective?

We rated it as good.

Assessment of needs and planning of care

Specialist eating disorder services

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

All young people referred to the service, who were interested in attending the day programme and considered potentially suitable, were seen and assessed by a consultant psychiatrist. The assessment appointment was two hours long. Parents and young people were sent questionnaires to complete prior to the assessment. A range of rating scales were used to assess the young person including children's anxiety and depression scale and eating disorder examination questionnaire.

If young people were not assessed as being able to benefit from the service, they were signposted to other services that could potentially better meet their needs.

Prior to starting in the programme, the young person met with one of the nursing team and usually a dietitian to prepare them for the eight-week day programme.

Young people underwent a physical health assessment and any required specialist physical health assessments and tests. Some were conducted in the service and others, such as blood tests, were carried out outside the service.

The consultant psychiatrist reviewed young people after two weeks in the programme and again after four weeks.

Nurses worked with the young people to develop care plans that addressed their needs. Goals were framed in terms of gaining enough weight to enable the young person to engage in sports and other physical activities and/or to be able to eat out. Each week the young person set four goals for themselves.

We reviewed three care plans as part of the inspection, all of the care plans were written in the young person's handwriting and were recovery orientated.

Best practice in treatment and care

Staff provided a range of treatment and care for young people based on national guidance and best practice. They ensured that young people had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

The service employed a sessional family therapist and offered family therapy to all young people and their families engaged in the programme.

Every young person saw a dietitian when they were admitted to the day programme.

Nurses monitored the physical health of young people in the programme on a weekly basis, including regular reviews of weight. Staff recognised when young people had deteriorated. When required young people were referred to other services such as inpatient services where their needs could be met.

Specialist eating disorder services

The day treatment programme involved group and individual therapeutic work. Depending upon individual progress staff supported young people to prepare their own food and facilitated eating out. The structured day programme ran over eight weeks. Some young people returned for a second eight-week programme to consolidate and further their progress.

Therapeutic groups provided in the eating disorders day programme included body image group, self-esteem group, creative arts, parents group and a MANTRA group adapted for young people from the Maudsley Model of Anorexia Treatment for Adults, an evidence-based approach.

Staff measured outcomes for the young person using a range of measures, including their weight and psychological measures such as the children's anxiety and depression scale and the eating disorder examination questionnaire. Young people completed outcome measure questionnaires at the beginning of therapy and every four to six weeks after that.

The care provided was very person centred. Key working sessions between a nurse and young person were structured each week, over the eight-week programme. For example, one week involved preparing individual dining room support cards for the young person. Another week focused on preparing a self-soothe box and the final weeks looked at ways of preventing relapse, understanding warning signs and triggers.

Young people were supported by two staff at mealtimes. There was a four-week meal menu that was then repeated. The menus were designed by a dietitian and prepared by the dietetic assistant. The young people always had a choice and were allowed to nominate three foods they disliked. The menu had been changed to make it more child friendly.

Skilled staff to deliver 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.

The team included or had access to the full range of specialists required to meet the needs of young people. The eating disorders service had two part time consultant psychiatrists, a sessional family therapist, two nurses, a dietetic assistant (who prepared the meals), an occupational therapist (also a primary therapist) and a sessional dietitian. A full-time substantive dietitian started work during the period of the inspection.

All staff described receiving regular supervision both managerial and clinical. Some staff also received external supervision.

Staff attended regular reflective practice meetings, with an external supervisor.

New staff were provided with a suitable induction.

Staff reported there were plenty of opportunities to develop their clinical skills. Staff in the eating disorders pathway were undertaking training in family therapy to support treatment programmes in the service.

Multi-disciplinary and interagency team work

Specialist eating disorder services

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

The MDT met weekly to discuss the care and progress of the young people. All staff we spoke with described good team working with other disciplines.

Staff worked closely with young people's schools in order to reintegrate them to full-time education. Nurses liaised with school staff around mealtimes and how to support the young people. Young people could bring their schoolwork with them into the service.

The clinic had good relationships with other services and staff were able to sign post and refer on young people when they could not meet their particular needs. For example, the service had strong relationships with nearby independent mental health hospitals and would make referrals if staff felt an inpatient stay was required.

Good practice in applying the Mental Capacity Act

Staff supported young people to make decisions on their care for themselves. They understood the service policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to people under 16. Staff assessed and recorded consent and capacity.

Staff supported young to make decisions about their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for young people who might have impaired mental capacity.

Staff had a detailed understanding of the Mental Capacity Act and Gillick competence. Eighty eight per cent of staff had completed their Mental Capacity Act training.

All three care records we reviewed evidenced that the young person had capacity to consent to treatment.

Are Specialist eating disorder services caring?

We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated young people with compassion and kindness. They understood the individual needs of young people and supported them to understand and manage their care, treatment or condition.

Staff treated young people with compassion and kindness and valued them as partners in their care. Feedback from young people and their parents or carers was overwhelmingly positive.

Specialist eating disorder services

The young person we spoke to described staff as “very chatty and friendly”. Relatives were also full of praise for the service. Relatives told us that the service treated their children with compassion and were always there for support. Many relatives praised the key workers for always being available to provide support for YP whenever it was required. One relative said that the key worker’s dedication to supporting their daughter was extraordinary.

We attended a body image group as part of the inspection. There were four young people present. The staff member treated the young people with dignity and kindness. The staff member running the group managed the group effectively and engaged all the young people in the group.

Involvement in care

Staff involved young people in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that young people had easy access to independent advocates. Staff informed and involved families and carers appropriately.

Involvement of young people and their families

The service invited young people to give feedback about their experience. Changes in the services had been made in response to feedback from young people. For example, some of the meals offered to young people were changed in response to their feedback.

There was a weekly community meeting for young people. The minutes of this meeting followed a “you said” “we did” format. Staff made changes in response to feedback during these meetings. For example, staff had agreed to help young people practice pancake day for whoever wanted to participate. Young people had been involved in the design of a guide to the eating disorders service and were invited to give feedback on the draft version.

A weekly feedback form for parents and young people was provided by the service. The assistant psychologist corroborated feedback and presented themes to the wider team.

Nurses followed up young people and saw them once a week after discharge.

Involvement of families and carers

We spoke to four family members of young people using the service. Everyone we spoke to held the service in the highest regard. All the family members said that the level of support provided by staff was greatly appreciated and they felt well involved in their loved one’s care.

Parents attended a psycho-educational group one evening a week when their children were taking part in the eating disorders programme. This had continued online during the pandemic. Former patients and parents of patients had spoken to the group and shared their experiences.

Parents and carers were encouraged to send feedback to the weekly multidisciplinary meeting. This included feedback on their child’s progress and any questions they had.

Are Specialist eating disorder services responsive?

Specialist eating disorder services

We rated it as good.

Access and waiting times

The service was easy to access. Its referral criteria did not exclude young people who would have benefitted from care. Staff assessed and treated young people who required care promptly and provided a service to suitable low risk young people. Staff followed up young people who missed appointments. Young people were discharged safely.

Referrals into the pathway came from GPs, other mental health services, or self-referrals. All referrals underwent an initial triage, to ensure the person might benefit from the service and was allocated for an assessment by a psychiatrist.

Five young people were attending the eating disorders day programme on the first day of our inspection visit. The programme could take up to eight young people at one time.

The service offered a day programme rather than outpatient treatment. Parents/young people who needed outpatient treatment were signposted to other services.

If accepted into the programme following assessment young people could start the day programme the next week.

If young people did not attend a planned session their key worker called them to check on their well-being.

On approaching discharge from the programme key workers discussed future aims and goals with young people and how they could achieve them. Together they prepared a relapse prevention plan. A discharge letter with the ongoing care plan was sent to the young person and their parents/carers and copied to the young person's GP.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported young people's treatment, privacy and dignity.

The service had several private consultation rooms, larger rooms for group therapy sessions, a kitchen area, and a large reception area. There was also a spacious treatment room. The environment was welcoming. COVID-19 measures were in place to protect young people and their families visiting the service.

Some of the interview rooms were not sound proofed. Staff were aware of this and were trialling the use of a white noise machine to ensure consultations and therapies remained confidential.

Meeting the needs of all people who use the service

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

Specialist eating disorder services

The service could support and make adjustments for young people with disabilities, particular communication needs or other specific needs. The service was accessible for young people using wheelchairs other mobility needs. A suitable toilet was located on the ground floor and a lift was available for the service.

Staff made sure young people could access information on treatment, local services, their rights and how to complain. This information was provided in a welcome pack provided to young people and families who were new to the service.

Managers obtained interpreters or signers when needed. The staff team was diverse, for some staff English was not their first language. Staff would help interpret for young people who did not speak English. A translation service was also available.

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.

Young people, relatives and carers knew how to complain or raise concerns. Young people and their families told us that they knew how to complain and would feel able to do so. The service had recently reintroduced a feedback box following the relaxation of COVID-19 restrictions.

Staff knew how to acknowledge complaints and complainants received feedback from managers after the investigation into their complaint. The service manager told us that they would try and resolve most complaints informally. The service had received two formal complaints between January 2021 and December 2021. For example, a complaint was upheld when the invoices were sent to the wrong address. The clinic director apologised to the complainant about this.

Managers shared feedback from complaints with staff and learning was used to improve the service. Feedback from complaints was a standing agenda item in the governance and quality meeting.

Are Specialist eating disorder services well-led?

We rated it as good.

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 young people and staff.

The senior management team had a good grasp and oversight of the services they managed. Senior leaders were experienced and had the knowledge and skills to undertake their roles.

Leaders we spoke to were passionate about the service and were committed to improvement.

Specialist eating disorder services

Staff were very positive about the leadership of the service. They said the registered manager who was relatively new, had brought good structure and clarity of vision to the service and governance arrangements. The registered manager was described as very helpful and supportive.

Vision and strategy

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

Staff felt told us that the provider's current vision for the service was to provide comprehensive and bespoke treatment for young people with an eating disorder. Parents fed back that this vision was being met. Young people and parents said that the service felt like it had been set up and adapted just for them.

The provider had recently sent new objectives to the service. The five strategic pillars were provider wide and were for all Schoen Clinics across England. The new pillars were in relation to recruiting the right people, delivering measurable outcomes of quality, increasing standardisation across UK services, delivering financial goals and to grow the size of the service. There were deliverables set out under each goal. For example, the provider planned to implement long service awards for staff, future leaders' academies and launch a healthcare hero recognition scheme to thank colleagues who go the extra mile. At the time of the inspection the service objectives were being reviewed to fit with the provider wide objectives.

Culture

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

The service manager felt there was good cohesion in the teams and felt that the team had responded well to the COVID-19 pandemic.

Staff described a positive, supportive and open culture. Staff were extremely committed to and passionate about their work. Staff said they could raise any concerns they had about care or the service and were certain they would be listened to. Staff described high levels of psychological safety in the team.

Staff had been asked to complete a satisfaction survey. An action plan to address the issues raised was being developed at the time of inspection.

Staff described that they felt the provider allowed ample opportunities for career progression. For example, an occupational therapist had recently been supported to become a family therapist. They were provided training for the role by the service.

Staff had access to external employee support should they required it. Information about this service was displayed in the staff room. The service was also in the process of appointing a freedom to speak up guardian.

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.

Specialist eating disorder services

There was a comprehensive and detailed governance system supporting staff to provide safe and high-quality care and treatment. There was an auditing programme in place although the service manager felt that the level of auditing was not sufficient during the previous year. The clinic director told us that in the previous year there had been a focus on the development of the programmes and getting the right people in place. During the inspection we identified a difference in quality of care planning between the two pathways. The service manager felt that this would be improved with an increased level of care and treatment record auditing.

Staff told us that clinical governance meetings took place bi-monthly. These meetings followed a fixed agenda. The meetings covered recent audits, feedback from complaints, staffing and recent safeguarding. Leadership meetings involving the registered manager and senior manager from the provider also took place monthly. This meeting covered areas such as service capacity, staffing and vacancies, the service risk register and incidents, complaints and safeguarding. The minutes of these meetings were stored in shared files so that all staff could access and read them.

Management of risk, issues and performance

The service had effective risk management systems in place.

The service had a risk register which outlined the current highest risks in the service. These risks reflected those we found during the inspection and reported by staff. At the time of inspection, the main risks on the risk register were, the clinical notes system, staffing and COVID- 19.

Managers carried out regular health and safety monitoring, including fire drills and infection control monitoring. The service had business continuity plans in place for emergencies.

Information management

The service provided staff with the appropriate technology to facilitate their roles and support the delivery of care and treatment, although staff felt the systems were not best suited to mental health care.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. Staff said they had sufficient computers to carry out their roles. Staff also told us that IT support were very responsive.

Staff often told us that they found the IT system difficult to navigate. Staff told us that this system had its limitations and was not best suited for mental health work. The clinical records system was on the risk register for the service. This was due to delays in accessing patient information and increased level of admin support required to manage work arounds. The provider had recently recruited a new head of IT. They were due to meet senior leaders at the service to discuss the functionality of the current system.

Engagement

The service encouraged and heard views from young people, carers, staff and external partners and acted on them to shape services.

Leaders at the service recognised the importance of having links to other services. They felt these links were important as some young people would require inpatient treatment and it was important that they worked with the services that they referred to.

Specialist eating disorder services

The service had recently become affiliated with an eating disorder charity. Two therapists within the service had been providing supervision to staff at the charity during the COVID-19 pandemic.

Learning, continuous improvement and innovation






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

There was a focus on continuous learning and improvement. Leaders at the provider had identified areas that they would like to improve. For example, leaders were looking at options to improve the IT system and care and treatment records.

The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements. For example, additional training was rolled out following a complaint about a data breach.

Community-based mental health services for adults of working age

Good 

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

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.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. Staff had recently completed risk assessments in relation to fire, health and safety, ligature risks and infection control.

All interview rooms had alarms and staff available to respond.

The clinic/treatment room was well equipped with the necessary equipment to carry out physical examinations and measure patients' weight and height. The examination couch was visibly clean and free from damage. All areas were clean, well maintained, well-furnished and fit for purpose.

Staff maintained equipment and kept it clean. Staff cleaned equipment after use. The service ensured equipment and medical devices were serviced and calibrated in line with the manufacturer's instructions. Records showed that weighing scales and height measures were checked monthly. The electrocardiogram machine had been serviced and repaired in February 2022.

Staff made sure cleaning records were up-to-date and the premises were clean. Domestic staff attended the service on Tuesdays, Thursdays and Fridays. The service manager felt this arrangement was working well. The training kitchen was clean and well organised. Sharps were locked away in a safe, the fridge temperature was regularly checked and food was labelled with opening and use by dates.

Staff followed infection control guidelines, including handwashing. At the time of inspection all staff were observed to be wearing appropriate personal protective equipment (PPE). PPE was readily available in the reception area for patients and staff to access. Hand sanitizer stations were located throughout the building. Staff maintained specific

Community-based mental health services for adults of working age

Good 

changes designed to minimise COVID-19 transmission. Cleaning requirements had increased since the pandemic. Chairs and desks in the service were set apart. Perspex screens had also been introduced to help separate desk space. Visitors were asked to complete a short form in relation to COVID-19 related information upon entry to the service. The service had recently had an independent infection prevention audit carried out. Overall, the service had a compliance rate of 77%. The service had produced an action plan to follow up the areas of non-compliance.

Staff checked the contents of the emergency equipment bag every month. Records showed that planned checks had been completed over the last six months. Staff checked the automated external defibrillator every week and ensured that the defibrillator pads were within the expiry date.

Safe staffing

The service had enough staff, who knew the patients and received appropriate training to keep them safe from avoidable harm. There were sufficient staff of different disciplines to ensure patients received the time they needed.

The service had enough staff to keep patients safe. All patients that we spoke with said that there were enough staff to meet their needs. At the time of inspection, the service had 2.9 whole time equivalent (WTE) vacancies, the majority of these vacancies were new posts created in the children and young people pathway. Interviews for these positions had been booked.

Therapy staff were made up of a combination of full time and part time workers.

Senior staff told us they were able to recruit staff based on the needs of patients. The clinic director told us that recruitment of specialist clinicians had been challenging. In response to this they had decided to recruit more junior staff and to develop them internally. For example, the service had recently recruited a therapy assistant in their second year of training.

The service did not use any bank or agency staff.

Managers supported staff who needed time off for ill health and sickness levels were low. Managers were able to plan to cover staff sickness and absence.

The service had enough medical staff, with two part time consultant psychiatrists in post. The capacity of one of the consultants was identified as a risk on the risk register. This was because in 2021 there had been a significant increase in referrals. The clinical notes were not always being added to patient records contemporaneously. The service took steps to address this. A new consultant for the anxiety and mood pathway had also been recruited to increase medical capacity within the service. The service was also looking to recruit another part time consultant psychiatrist at the time of inspection.

The service could get support from a psychiatrist quickly when they needed to.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. Training compliance ranged from 80% to 100% in the service.

Community-based mental health services for adults of working age

Good 

The mandatory training programme was comprehensive and met the needs of patients and staff. The training included, fire safety, resuscitation, safeguarding, mental health awareness and mental capacity training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers would discuss training compliance during regular supervision.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients to develop crisis plans.

Assessment of patient risk

The private enquiries manager carried out an initial screening of referrals to see whether they were suitable for and could benefit from the service. They explained the service that was offered to adults and to young people, explained the inclusion and exclusion criteria and signposted referrers to other more appropriate services when needed. The private enquiries manager had received training to determine whether the service could potentially meet the prospective patient's needs. If they had any doubts or were unsure, they consulted with a clinician. They always checked whether the patient had a clinician such as a GP or consultant psychiatrist involved in their care already. Following the initial triage, patients were allocated to a consultant psychiatrist or clinical psychologist for a comprehensive assessment of their needs and risks.

The anxiety and mood disorders programme had clear inclusion and exclusion criteria. The service did not take on high risk people. The exclusion criteria stated the service should not take on people with; psychosis, a primary diagnosis of personality disorder, active substance misuse or active suicidal planning.

Risk assessments were completed by the key worker in their first key work session with the patient. The risk assessment was reviewed every four weeks or more frequently if new risks arose. Risk assessments were reviewed again on discharge from the programme.

Management of patient risk

We reviewed five patient care and treatment records as part of the inspection. It was not always clear from reviewing the risk assessments how patient risks were being managed. For example, for a service user who was considered to be a high risk of substance misuse, it was not clear from reading the risk assessment what the service was doing to mitigate this risk. Following a further review of the patient's progress notes and discussing the patient with the lead consultant it was clear that staff had appropriately signposted the service user to other organisations. The service was also recording the patient's vital signs on a weekly basis so that they could monitor their physical health and they were aware that the patient was regularly seeing their GP. The service manager told us that the patient's risk assessment would be updated to show the risk management processes in place. The service manager was keen to adapt the current electronic system as they felt it did not allow staff to complete risk assessments effectively.

Staff responded promptly to any sudden deterioration in a patient's health. All patients on the anxiety and depression pathway were discussed during a weekly multidisciplinary team (MDT) meeting. The notes from this meeting were added to each patient's progress notes. These notes were comprehensive and discussed each patient's risk at the time of the meeting.

Staff continually monitored patients on waiting lists for changes in their level of risk and responded when risk increased.

Community-based mental health services for adults of working age

Good 

Staff would ask for a patient's permission to share information about their care and treatment with their GP. If a patient declined to give consent for the service to contact their GP, the service doctor discussed this with the patient during their assessment and future sessions. The consultant would also explain the risks of not sharing the information. However, some patients did not give permission for the service to share information with their GPs. The consultant told us that he would adapt letters alongside the patient so that they were happy with the level of information shared.

Adults and children and young people used services in the building. The service kept the two age groups apart to maintain safety. Staff escorted children and young people around the building at all times to prevent any contact with adults.

Staff could recognise when to develop and use crisis plans and advanced decisions according to patient need. Crisis information was passed on by the administration team when required. Service users were provided with an induction pack when they started which contained various documents including crisis contact details. Patients who were higher risk were given contact details for their local crisis lines instead of the more generic 111. Key workers also had conversations with patients about what to do in a crisis.

Safeguarding

Staff understood how to protect patients from abuse, however staff did not always complete a full record to demonstrate the reasons why they had not made referrals to the local authority .

Staff received training on how to recognise and report abuse, appropriate for their role and staff kept up-to-date with their safeguarding training. The service had four mandatory training modules about safeguarding children and adults. Compliance ranged from 80% to 100% for these modules.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The clinic director told us that they had previously raised a safeguarding concern to the local authority. The clinic followed this up with the local authority to ensure that social services had conducted a welfare check and that there were no safeguarding concerns.

However, we reviewed one patient care and treatment record where safeguarding concerns were identified. Staff were concerned that a patient may be at risk of domestic violence. The care and treatment records did not provide suitable assurance that staff had put sufficient safeguards in place to protect the patient. The team decided a safeguarding referral to the local authority was not appropriate. Staff told us that these concerns were discussed during the weekly MDT meeting and it was decided that the threshold for a safeguarding referral was not met, this decision was not documented. When this was raised at the time of the inspection the clinic director accepted that this decision should have been documented. The service manager told us that staff would be reminded about the importance of documenting key decisions.

Staff knew who the safeguarding lead for the service was and staff had contact details for social workers at the local authority and the local authority safeguarding team.

Staff access to essential information

Community-based mental health services for adults of working age

Good 

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

Most patient progress notes were detailed and contained input from across the MDT. However, some care plans and risk assessments were not sufficiently detailed. It was clear from the progress notes that staff were meeting patients' needs and patients were heavily involved in their care and treatment, but this was not always clearly recorded in patient care plans and risk assessments.

The records system was adopted from a physical health service under the same provider. Staff told us that this system had its limitations and was not best suited for mental health work. The clinic director was keen to adapt the current system so that staff could navigate and complete records more easily. However, a final decision on this was yet to be made since a case was put forwards to the provider over a year ago.

Records were stored securely. All computer systems were accessed by individual usernames and passwords.

Medicines management

The systems and arrangements for managing medicines and equipment minimised risks. The service kept prescription stationery securely and monitored its use. Prescriptions could be collected by patients or would be delivered via specialist courier.

Medical staff prescribed medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.

No medicines were stored on site.

Track record on safety

The service had a good track record on safety.

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.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with provider policy. Incidents were reviewed during bi-monthly team meetings. For example, between October and December 2021 there were no serious incidents but there were 12 lower level incidents. These incidents were discussed in the January governance and quality meeting. During these meetings staff would be reminded to report all incidents using the electronic incident reporting system.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. For example, staff apologised to a patient when the subject line of a confidential email included the patients full name.

Community-based mental health services for adults of working age

Good 

Managers told us they would debrief and support staff after any serious incident. Due to the service seeing low risk patients this had not been required by the time of the inspection.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

There was evidence that changes had been made as a result of feedback. For example, there had been a few incidents related to GDPR. The learning from this incident was that all staff received further training about information governance. All staff reminded were reminded of the importance of checking information in emails before sending during a recent governance and quality meeting.

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

Good 

We rated it as good.

Assessment of needs and planning of care

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

As part of the inspection we reviewed five patient care and treatment records. Staff completed a comprehensive mental health assessment of each patient. Although the assessments did not follow a standard template they were detailed. Where appropriate this included their clinical needs and their mental and physical wellbeing. The consultant completed a full assessment of each patient at their first appointment.

Staff made sure that patients had a full physical health assessment and knew about any physical health problems. For example, staff were concerned about a patient's body weight and general wellbeing, which was identified during the initial assessment. In response to this the patient's physical health observations were recorded on a weekly basis and a blood test was requested from the patient's GP. The clinic director felt that the physical health checks had been enhanced since the recruitment of an additional nurse.

Three out of five care plans we reviewed were generic and lacked the necessary level of individual detail. Information that was present in the patients' progress notes was not always documented in the care plan. When speaking to staff and patients it was clear that patients were heavily involved in their care and treatment, but this was not always evident in the care plans. All patients that we spoke to told us that they had a copy of their care plan. The clinic director acknowledged that this was an area that required further work for the anxiety and mood pathway.

Staff regularly reviewed and updated care plans when patients' needs changed. Key workers met regularly with their patients and updated care plans during these sessions.

Community-based mental health services for adults of working age

Good 

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

In the anxiety and mood day programme patients were offered a range of evidence based therapeutic groups alongside individual therapeutic input. Each patient had a keyworker who worked with them to set individual goals and determine the care and support they needed to achieve those goals. The groups provided included integrated cognitive behaviour therapy, compassion focused therapy, mindfulness, dialectical behavioural therapy and schema therapy, designed to address deeper level maladaptive schematic beliefs and interpersonal patterns that are not responsive to first-line therapeutic approaches.

Staff measured clinical outcomes for patients using different measures such as patient health questionnaire (PHQ-9), which measures depression; generalised anxiety disorder assessment (GAD-7); and work and social adjustment scale (WSAS), a measure of the impact a person's mental health difficulties on everyday functioning. Patients completed outcome measure questionnaires at the beginning of therapy and every four to six weeks after that. The clinic director felt that the service was good at using outcome measures at the beginning of a patient's treatment but were less likely to use the outcomes towards the end of treatment. The clinic director told us that increasing the use of outcome measure for patients near discharge was an objective for 2022.

Where appropriate, staff gave people advice so they could self-care. For example, they provided guidance on straightforward ways to reduce the effects of depression such as ensuring patients got enough sleep and avoided alcohol.

Staff made sure patients had support for their physical health needs, either from their GP or community services. For example, the consultant had requested that a patient's GP conduct a thyroid function test. Staff told us that the level of collaboration between GPs and the service varied.

Staff used technology to support patients. Staff provided text, telephone and video call support which patients found particularly helpful. Patients could now access appointments online in response to the COVID-19 pandemic. Managers in the service were keen to continue a hybrid service in the future with virtual and face to face appointments available.

Staff took part in clinical audits. The service had an audit schedule in place. Care plans and risk assessments were audited on a quarterly basis. This audit reviewed all current day patients to ensure they had a current care plan and risk assessment in place. These audits did not always assess the quality of the care plans and risk assessments. The clinic director felt that the auditing could be more detailed and had plans to implement a more detailed qualitative audit of care and treatment records.

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.

Community-based mental health services for adults of working age

Good 

The anxiety and mood pathway team included or had access to the full range of specialists required to meet the needs of patients. The anxiety and mood service had two part time consultant psychiatrists, a psychotherapist, primary therapists, assistant psychologists and an occupational therapist.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care.

Managers gave each new member of staff a full induction to the service before they started work. We spoke to a recent new starter, they told us that the induction was very thorough. It covered a tour round the centre, protected time to review the policies and procedures and mandatory e-learning. Newly recruited staff told us that they felt comfortable asking colleagues for support if they were unsure about procedures at the service.

Managers supported permanent medical staff to develop through yearly, constructive appraisals of their work. The anxiety and mood pathway consultant received their supervision and revalidation from an NHS mental health trust who they were also working for. The consultant also told us that the clinical director for the provider was also assessable and could readily provide advice on complex cases.

All staff described receiving regular supervision both managerial and clinical. Some staff also received external supervision. Between January 2021 and December 2021, the average monthly clinical supervision completion rate was 95%. It was 90% for managerial supervision during the same time period. Staff told us that they regularly received supervision and felt able to approach their managers as and when required. Staff attended regular reflective practice meetings, with an external supervisor.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. Team meetings covered the performance of the service, such as staffing, audits, learning from incidents, complaints and compliments. Detailed minutes of the meetings were recorded and shared with staff after the meeting.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us that they were able to access specialist training.

Managers recognised poor performance, could identify the reasons and dealt with these.

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 team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff from different disciplines met at the beginning and end of most days to handover important messages and to briefly discuss patient care. The MDT met weekly to discuss the care and progress of the patients in the anxiety and depression programme.

The clinic had good relationships with other services and staff were able to sign post and refer on patients when they could not meet their particular needs. For example, the service had strong relationships with nearby independent mental health hospitals and would make referrals if staff felt an enhanced level of care was required.

Community-based mental health services for adults of working age

Good 

All patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service. When patients had reservations about sharing information with the GP, the doctor explained the importance of information sharing and agreed the text of the GP letter with the patient.

Good practice in applying the Mental Capacity Act

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

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

Staff had a detailed understanding of the Mental Capacity Act and 88% of them had completed their Mental Capacity Act training.

Staff were clear about recording consent for care and treatment and each patient was expected to complete a consent form upon admission to the service. This included information about whether the patient consented to their information being shared with their family or carers and external services.

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

Good 

We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

As part of this inspection we spoke to four patients. Every patient we spoke to was overwhelmingly positive about the care they had received or were receiving at the service. All the patients praised the staff and told us how they had helped put them at ease. One patient said that the kindness they received from everyone from the reception staff to the consultant made them feel accepted for who they are. Multiple patients told us that the service had changed their lives for the better.

We reviewed written feedback from four patients and a patient's relatives using the anxiety and depression day service. Patients were very positive about their experience. They described therapists as warm, kind, compassionate and sensitive. One patient described how 'every effort was made to accommodate each patient on an individual basis in a kind and caring manner', another patient described therapeutic group sessions as 'simply superb.'

Staff provided practical help, emotional support and advice to patients when they needed it. Patients told us about the various therapy groups and one to one sessions they took part in.

Community-based mental health services for adults of working age

Good 

Staff directed patients to other services and supported them to access those services if they needed help. For example, the service would refer patients for inpatient treatment if required.

Staff understood and respected the individual needs of each patient. Patients told us that staff at the service made them feel like they were the only patient at the service. Patients said that the service was tailored to their needs.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients and staff. Staff told us that managers had an open-door policy and they would feel comfortable raising concerns.

Staff mostly followed policy to keep patient information confidential. There had been a few incidents when patient information was shared accidentally. For example, a patient's name was shared in the subject line to another service user. In response to this all staff received further training in information governance and the patient received an apology.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

We reviewed five patient care and treatment records, when reviewing the patient progress notes and speaking to patients it was evident that care was centred around the patient. However, care plans did not always make it clear that patients had been involved in their care and treatment.

Staff made sure patients understood their care and treatment. All patients we spoke to said that staff would take the time to explain any complex issues in relation to their care and treatment.

Staff involved patients in decisions about the service, when appropriate. The service invited patients to give feedback about their experience and made changes in response. For example, in the adult day service a physical health focused group had been introduced after suggestions from patients.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients were frequently asked to provide feedback on the service, this was done by completing a feedback questionnaire. The survey asked questions about how likely patients would be to recommend the service to friends and family and how they would rate their treatment at the service. There was also a free text option at the bottom of the survey. We saw nine recently completed surveys, all of which were overwhelmingly positive about the care and treatment the patients had received.

Involvement of families and carers

Staff informed and involved families and carers appropriately. Staff would ask patients if they would like their family involved in their care.

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

Community-based mental health services for adults of working age

Good 

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 assessed and treated patients promptly.

Referrals into the pathway came from GPs, other mental health services, or self-referrals. All referrals underwent an initial triage, to ensure the person might benefit from the service and allocated for an assessment by a psychiatrist or sometimes a clinical psychologist.

The anxiety and depression service had clear inclusion and exclusion criteria. Inclusion criteria included a range of problems such as depression, anxiety and obsessive-compulsive disorder, that had a significant impact on people's lives and relationships. Exclusion criteria included people who were actively suicidal or suffering from psychosis or addictions. The adult service received more referrals for outpatient support than they had capacity. Patients that could not be accepted were signposted to another service.

Patients in the anxiety and depression service usually attended groups over an eight-week cycle although individual therapy could go on for much longer.

There were 11 patients using the day programme in the anxiety and depression service at the time of the inspection, attending different groups. About 35 people had been through the programme in the last 12 months. Group sizes were a maximum of eight or nine in a group, although more usually five or six. All groups were held face to face. Although the service had offered virtual groups during the pandemic this was now all face to face. Some individual therapy was provided virtually as well as people receiving face to face sessions.

If patients did not attend a planned session their key worker called them to check on their well-being.

On approaching discharge from the programme key workers discussed future aims and goals with patients and how they could achieve them. Together they prepared a relapse prevention plan. A discharge letter with the ongoing care plan was sent to the patient and copied to the patient's GP.

The consultant psychiatrist for the anxiety and mood pathways said the discharge timeframes were more fluid for the adult service than the children and young people service. This was because the care plans needed to fit around personal circumstances such as working patterns. Regular reviews would be completed and step-down options considered. Group therapy moving to individual therapy was part of the discharge plan and could continue for months after assessment. Some service users would want to remain in touch periodically or have booster sessions with the consultant psychiatrist or therapists.

Patients had some flexibility and choice in the appointment times available. In response to the COVID-19 pandemic face to face appointments and online appointments were available. Patients told us that appointments were readily available and they would be scheduled to fit alongside their other commitments.

Community-based mental health services for adults of working age

Good 

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 number of private rooms, larger rooms for group therapy sessions, a kitchen area, and a large reception area. There was also a spacious treatment room. The environment was welcoming, and COVID-19 measures were in place to protect patients visiting the service.

Some of the interview rooms were not sound proofed. Staff were aware of this and were trialling the use of a white noise machine to ensure consultations and therapies remained confidential.

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 could support and make adjustments for people with disabilities, communication needs or other specific needs. The service was accessible for patients using wheelchairs and patients with other mobility needs. A suitable toilet was located on the ground floor and a lift was available for the service.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. This information was provided in a welcome pack provided to patients who were new to the service.

Managers made sure staff and patients could get hold of interpreters or sign language interpreters when needed. The staff team was diverse, for some staff English was not their first language. Staff would help translate for patients who did not speak English. A translation service was also available.

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.

Patients, relatives and carers knew how to complain or raise concerns. All patients told us that they knew how to complain and would feel able to do so. The service had recently reintroduced a feedback box following the relaxation of COVID-19 restrictions.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The service manager told us that they would try and resolve most complaints informally. The service had received two formal complaints between January 2021 and December 2021.

Managers shared feedback from complaints with staff and learning was used to improve the service. Feedback from complaints was a standing agenda item in the governance and quality meeting.

Community-based mental health services for adults of working age

Good 

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

Good 

We rated it as good.

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.

The senior management team had a good grasp and oversight of the services they managed. Senior leaders were experienced and had the knowledge and skills to undertake their roles.

Leaders we spoke to were passionate about the service and were committed to improvement.

Staff were very positive about the leadership of the service. They said the registered manager who was relatively new, had brought good structure and clarity of vision to the service and governance arrangements. The registered manager was described as very helpful and supportive.

Vision and strategy

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

Staff felt told us that the providers current vision for the service was to provide comprehensive and bespoke treatment for patients. Patient feedback showed that this vision was being met. Patients said that the service felt like it had been set up and adapted just for them.

The provider had recently sent new objectives to the service. The five strategic pillars were provider wide and were for all Schoen Clinics across England. The new pillars were in relation to recruiting the right people, delivering measurable outcomes of quality, increasing standardisation across UK services, delivering financial goals and to grow the size of the service. There were deliverables set out under each goal. For example, the provider planned to implement long service awards for staff, future leaders academies and launch a healthcare hero recognition scheme to thank colleagues who go the extra mile. At the time of the inspection the service objectives were being reviewed to fit with the provider wide objectives.

Culture

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

The service manager felt there was good cohesion in the teams and felt that the team had responded well to the COVID-19 pandemic.

Community-based mental health services for adults of working age

Good 

Staff described a positive, supportive and open culture. Staff were extremely committed to and passionate about their work. Staff said they could raise any concerns they had about care or the service and were certain they would be listened to. Staff described high levels of psychological safety in the team.

Staff had been asked to complete a satisfaction survey. An action plan to address the issues raised was being developed at the time of inspection.

Staff described that they felt the provider allowed ample opportunities for career progression. For example, an occupational therapist had recently been supported to become a family therapist. They were provided training for the role by the service.

Staff had access to external employee support should they required it. Information about this service was displayed in the staff room. The service was also in the process of appointing a freedom to speak up guardian.

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.

There was a comprehensive and detailed governance system supporting staff to provide safe and high-quality care and treatment. There was an auditing programme in place although the service manager felt that the level of auditing was not sufficient during the previous year. The clinic director told us that in the previous year there had been a focus on the development of the programmes and getting the right people in place. During the inspection we identified a difference in quality of care planning between the two pathways. The service manager felt that this would be improved with an increased level of care and treatment record auditing.

Staff told us that clinical governance meetings took place bi-monthly. These meetings followed a fixed agenda. The meetings covered recent audits, feedback from complaints, staffing and recent safeguarding. Leadership meetings involving the registered manager and senior manager from the provider also took place monthly. This meeting covered areas such as service capacity, staffing and vacancies, the service risk register and incidents, complaints and safeguarding. The minutes of these meetings were stored in shared files so that all staff could access and read them.

Management of risk, issues and performance

The service had effective risk management systems in place

The service had a risk register which outlined the current highest risks in the service. These risks reflected those we found during the inspection and reported by staff. At the time of inspection, the main risks on the risk register were, the clinical notes system, staffing and COVID- 19.

Managers carried out regular health and safety monitoring, including fire drills and infection control monitoring. The service had business continuity plans in place for emergencies.

Information management

The service provided staff with the appropriate technology to facilitate their roles and support the delivery of care and treatment, although staff felt the systems were not best suited to mental health care.

Community-based mental health services for adults of working age

Good 

Staff had access to the equipment and information technology needed to do their work. Staff said they had sufficient computers to carry out their roles. Staff also told us that IT support were very responsive.

Staff often told us that they found the IT system difficult to navigate. Staff told us that this system had its limitations and was not best suited for mental health work. The clinical records system was on the risk register for the service. This was due to delays in accessing patient information and increased level of admin support required to manage work arounds. The provider had recently recruited a new head of IT. They were due to meet senior leaders at the service to discuss the functionality of the current system.

Engagement

The service encouraged and heard views from patients, carers, staff and external partners and acted on them to shape services.

Leaders at the service recognised the importance of having links to other services. They felt these links were important as some young people would require inpatient treatment and it was important that they worked with the services that they referred to.

The service had recently become affiliated with an eating disorder charity. Two therapists within the service had been providing supervision to staff at the charity during the COVID-19 pandemic.

Learning, continuous improvement and innovation

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

There was a focus on continuous learning and improvement. Leaders at the provider had identified areas that they would like to improve. For example, leaders were looking at options to improve the IT system and care and treatment records.

The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements. For example, further information governance training was rolled out following a complaint due to a data breach.