

Early Years Parenting Unit

Quality Report

38 Mayton Street
London
N7 6QR
Tel: 02077942313
Website: www.annafreud.org

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

Ratings

| | | |
|---|-------------|---|
| Overall rating for this location | Good |  |
| Are services safe? | Good |  |
| Are services effective? | Good |  |
| Are services caring? | Good |  |
| Are services responsive? | Good |  |
| Are services well-led? | Good |  |

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

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

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

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

Summary of findings

Overall summary

We rated this service as good because:

- The service had been set up following evidence-based national guidance for the treatment and support of the patient group and had successfully demonstrated positive outcomes for families over time. The staff team were highly motivated and dedicated to working with the parents and children.
- The team was made up of qualified and experienced clinical staff who delivered therapeutic interventions, but also a group of qualified and experienced staff to support and care for the children.
- Patients said staff were skilled at delivering the treatment and supporting patients to engage in therapy. The service had a welcoming and comfortable environment, for both parents and children. Staff supported patients to overcome barriers of access to services and made sure they were involved in goals for treatment. Staff regularly discussed treatment and goals with parents and shared written copies of paperwork relating to their care.
- Staff understood the specific risks to parents and children accessing the service and managed these appropriately. Staff kept in close contact with, and provided clear and meaningful feedback to, social workers in the local authority who were involved in families' care. The service provided local authorities with clear information about what the service offered and who would be most appropriate to refer.
- Governance systems ensured the environment was safe, staff could access training and had appropriate employment checks in place. Staff collected and monitored treatment outcomes on a regular basis and this was led by a research officer.
- The service addressed the recommendations made in the last inspection. This included embedding a system for reporting and learning from incidents, ensuring mandatory training covered all necessary areas and that all staff had up to date criminal records checks. The service was open to feedback and made changes where necessary.
- Staff said the team worked well together and were supported well by the clinical services manager. Staff received regular supervision where they were supported with their own professional development and reflective practice.
- Staff kept up-to-date and accurate records about care whilst maintaining patient confidentiality.

Summary of findings

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Good 

Location name here

Services we looked at:

Community-based mental health services for adults of working age

Summary of this inspection

Our inspection team

The team was comprised one CQC inspector, one assistant inspector and one specialist advisor with experience of working in similar services.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

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

During the inspection visit, the inspection team:

- visited the service and looked at the quality of the ward environment and observed how staff were caring for patients

- spoke with four patients who were using the service
- spoke with the clinical manager of the service
- spoke with four other staff members; including therapists, the programme coordinator and the research officer
- spoke with a social worker employed by the local authority who worked closely with the service
- looked at seven treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

Information about Early Years Parenting Unit

The Early Years Parenting Unit was set up as part of The Anna Freud Centre, a children's mental health charity providing support and treatment to children, young people and families. The unit is a specialist service offering assessment and therapy for parents with personality disorders or related difficulties. It is for parents with babies and children under the age of five who are subject to child in need or child protection plans, or who are on the edge of care. All children have an allocated social worker assigned to them. The programme offers treatment for up to 10 families at a time. The unit receives referrals from social services. Unit

staff assess families over a 12 week period to see whether they would benefit from the programme. Once accepted to the programme, parents and children attend the unit together over an 18 month period for two days each week. The structure of the programme is fixed and there is a timetable of activities throughout the day which includes group meetings, breaks and lunch.

The clinical team is made up of a clinical service manager and three therapists. The clinical team is supported by a project coordinator, research officer and intern.

Summary of this inspection

The Early Years Parenting Unit has been inspected on two previous occasions. At the last inspection in May 2016, we issued three requirement notices:

- The provider must ensure mandatory training courses include those staff can use to maintain the safety of patients. This includes fire safety, infection control, basic first aid, Mental Capacity Act training and training in the Children Act 2004.
- The provider must ensure that staff report safeguarding incidents to the local authority.
- The provider must notify the Care Quality Commission of incidents in line with statutory requirements.

There is a registered manager in place.

What people who use the service say

Patients spoke positively about their experience of the service. They said staff were skilled and that they listened to them and taught them skills and strategies to manage their emotions. They said at times treatment could be stressful, but staff were patient and kind and explained

how treatment worked. Patients said the volunteer staff, who looked after children when parents attended therapy sessions, were a very helpful resource and good at what they did.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as good because:

- Staff identified and managed risks well, including any potential safeguarding risks. Staff communicated regularly with social workers from the local authority involved with the family, keeping them updated about progress and/or risks. This was explained clearly to patients.
- Staff carried out safety checks and risk assessments to keep the environment safe and clean for both the parents and the children.
- There were enough staff to provide treatment to parents and care for children. The staff employed to care for the children were qualified to do so and parents said they cared well for the children.
- Staff kept documentation up-to-date and crisis plans were embedded into care records. Staff reported and discussed incidents where necessary.
- Since the last inspection in May 2016, the service had successfully addressed several areas of improvement. The service now ensured staff received a range of appropriate mandatory training, all staff had up-to-date criminal record checks in place.

Good



Are services effective?

We rated effective as good because:

- Parents said that the service had helped them understand how to better manage emotions and staff were good at supporting them with this and giving them time to learn. Where families demonstrated they had improved parenting sufficiently to meet the needs of their children, alternative placements for the children could be avoided.
- Clinical staff delivered interventions based on national guidance relevant to people with personality difficulties and used outcome measures to rate the severity of illness and effectiveness of treatment. The service employed a research officer who was responsible for outcome measures and had dedicated time to collect and report on them.
- Services assessed the needs of each family and created individualised plans for care with input from parents.
- Staff were supervised regularly and met for clinical supervision and reflective practice weekly.

Good



However:

Summary of this inspection

- Although staff had introduced one audit since the last inspection, there was scope for more audits to be done. These could provide senior staff the assurance of the quality of services and any identify areas for improvement.

Are services caring?

We rated caring as good because:

- Patients were very positive about the service and the staff. They said staff listened to them and provided support and information that encouraged them to learn new skills to cope with difficult situations and emotions.
- Staff actively involved patients in their own care through discussion and regular review of plans.
- Staff made it clear from the start of treatment that they would be working closely with social workers in the local authority, but maintained confidentiality about care within the service itself.
- Patients could give feedback about care through surveys they completed every six months.

Good



Are services responsive?

We rated responsive as good because:

- The environment was welcoming and comfortable and patients gave positive feedback about it. There was a large playroom and garden area with a climbing frame where children had space to play and lots of toys to choose from. There were also children's bathrooms and a changing area for parents to use when needed.
- The service had clear acceptance criteria. Staff also spent 12 weeks assessing parents' ability to engage and benefit from the treatment course, before they were accepted. This allowed time for staff to come to a clear decision based on interaction over the 12 weeks with the family.
- Staff identified difficulties that families might have in accessing services, which were particular to the patient group, and worked with families to overcome these.
- Patients knew how to complain and staff handled complaints appropriately.

However:

- The service had plans in place to create a quiet space for children to nap during the day, but these were not yet completed. Staff offices were sometimes used for this at the time of inspection.

Good



Summary of this inspection

- The provider recognised the need to explore how to offer patients the option of independent review of complaints, if they were not happy with the initial outcome.
- The service was unable to offer treatment to people with language or communication barriers. For example, people who could not speak English or were deaf.

Are services well-led?

We rated well-led as good because:

- The service had effective governance systems in place to ensure services met the needs of the patient group.
- The service had successfully addressed several areas of recommendation from our last inspection and had embedded these into practice well.
- Staff were happy and proud to work at the service and enjoyed working with the patient group.
- Leaders had the knowledge, skills and expertise to perform their roles well.

Good



Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

The service did not work with people who were subject to detention under the MHA and staff did not receive mandatory training in this area. All clinical staff were qualified mental health practitioners.

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff received training in the Mental Capacity Act 2005 as part of their level two safeguarding training. The service did not work with patients who would be subject to Deprivation of Liberty Safeguards.

All patients signed consent to treatment forms staff explained to patients their right to withdraw consent at any time. The children involved in treatment were under five years old and parental consent was applied appropriately.

Overview of ratings

Our ratings for this location are:

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

Community-based mental health services for adults of working age

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

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

Good 

Safe and clean environment

At the last inspection in May 2016, staff did not regularly assess the environment for risks. During this inspection, we saw service now assessed the environment regularly and addressed any arising issues quickly.

All areas were clean, had good furnishings and were well-maintained. Up-to-date cleaning records demonstrated that an external company cleaned the environment regularly. There was a comprehensive cleaning schedule in place for toys to ensure infection control principles were upheld and the risk of the spread of infection was reduced.

Staff followed infection control principles, including handwashing and there were signs about this available throughout the service.

At the last inspection in May 2016, we found that staff did not keep daily records of the fridge temperatures where patient and staff kept food. During this inspection, we saw daily recording was now in place. Senior staff renewed the policy on food hygiene to include instruction on this and staff were aware of this policy.

An external company assessed the service regularly for fire safety risks. Staff addressed any required actions quickly and kept detailed records of this. Staff were trained in fire safety and a fire marshal was always on shift. The project

coordinator was responsible for ensuring all other safety assessments, such as gas and portable appliance testing, took place, and they kept up-to-date records to demonstrate this.

There was a first aid box available in the kitchen. It was well stocked and all items were within date.

Safe staffing

The provider was commissioned to support up to 10 families at a time and staffing levels were fixed to meet their needs. Clinical and research staff had appropriate qualifications for their roles. Volunteers, who had the appropriate qualifications and employment checks, such as criminal record checks, also worked at the service for up to 12 months at a time in the role of child carer. Patients said there was a good amount of staff to look after the needs of parents and children.

Each therapist was a keyworker for up to three families at one time. Staff had access to weekly supervision and reflective practice with the clinical service manager and wider team.

There was a very low turnover and sickness rate for staff. The service did not need to use locum, bank or agency staff.

The service had rapid access to a psychiatrist when required.

At the last inspection in May 2016, we found that mandatory training did not include some expected areas, such as infection control and the Children Act 2004. At this inspection, we saw the service had taken several actions to ensure these were now delivered to all staff during induction. The provider also introduced systems to monitor this and identify any new training needs.

Community-based mental health services for adults of working age

At the last inspection in May 2016, we found that some volunteer staff did not have updated certificates for criminal records checks. During this inspection, we reviewed a sample of criminal records checks for staff employed by the provider and saw this had been addressed. Where certificates were due to expire, the human resources staff ensured the necessary information was resubmitted and up-to-date criminal record certificates were in place.

Assessing and managing risk to patients and staff

Records showed that staff did a risk assessment of every family and updated this after the family had been at the service for six weeks. After this time, the risk assessments were reviewed every 12 weeks, or if a new risk arose. Staff recorded any changes in clinical presentation in daily clinical notes and discussed this at weekly supervision sessions. Staff demonstrated an awareness of the individual risks for parents and children and how they managed these.

Records showed patients' views and opinions were well documented, including in risk assessments.

At the last inspection in May 2016, staff did not use crisis plans with patients as well as they could have been. During this inspection, the service manager had worked with staff to introduce this into routine practice. Records showed staff completed written plans for patients to follow in a crisis. The service did not offer crisis or out-of-hours services, so staff and patients created plans to identify what other services were available for support if a crisis were to occur.

Management of risk

Staff could respond promptly to sudden deterioration in a patient's health and seek the advice of the service manager and project leads, who were senior clinicians.

The service did not run a waiting list. If there was no available space for a new referral, staff made this clear to referrers who had to find a different source of support for the families. At the time of inspection, there were six families involved in treatment.

The service had developed good personal safety protocols, including lone working practices, and there was evidence that staff were aware of and followed them.

Safeguarding

Staff were trained in safeguarding, knew how to make a safeguarding alert, and did so when appropriate. Staff shared information regularly with social workers involved with the families.

At the last inspection in May 2016, we found some staff had not always informed the local authority of safeguarding incidents. During this inspection, this was no longer the case. Records showed staff shared all necessary information with the local authority and discussed safeguarding incidents weekly as a team.

Staff access to essential information

Staff kept care records on the computer. Where information was shared with patients, it was printed off and patients were given a copy. The service manager also kept supervision records on the computer in individual staff files, so could access them easily.

All information needed to deliver patient care was available to all relevant staff when they needed it and in an accessible form. Staff understood the need for confidentiality and followed information governance guidance when sharing information with third parties. They sought consent from patients where appropriate.

Medicines management

Staff did not administer medication as part of the intervention offered by the service. There were no medicines stored on site.

Track record on safety

The service had an incident reporting policy, which outlined types of incidents, including serious incidents. There had been no serious incidents at the service within the last 12 months.

Reporting incidents and learning from when things go wrong

Staff knew which incidents to report and how to report them, using a paper incident form that was shared with the service manager. As the service was small, some incidents, such as a slow IT connection, were escalated immediately by the clinical service manager to the provider to ensure prompt action. We did not see IT incidents recorded as an incident on the paper recording form, but these issues were managed well by their service manager outside of this system.

Community-based mental health services for adults of working age

The serious and untoward incident policy outlined staff responsibilities under the duty of candour. Staff were able to demonstrate a knowledge of their responsibility to be open and transparent, and explained to patients and families if and when something went wrong. Where incidents had taken place that did not reach the threshold of serious incidents, staff had still been open with patients and informed them what had taken place and what the service were doing about it.

Staff met to discuss reported incidents and outcomes regularly. Since the last inspection, allocated time was given in team meetings to discuss incidents and record necessary actions. A six monthly audit was also completed for all safeguarding incidents, with the most recent dated June to November 2017. This allowed staff to identify patterns for action or learning and allowed the service manager an overview of whether staff were completing forms accurately.

Staff were debriefed and received support after incidents. Where necessary, senior staff from the overall provider also attended the service to provide support to the team.

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

(for example, treatment is effective)

Good 

Assessment of needs and planning of care

Staff completed a comprehensive assessment of the needs of each family over the assessment period, as well as their ability to engage and benefit from the programme.

During the assessment process, staff asked patients about their physical health and discussed how to access physical health support through their GP. There was information available on notice boards about local services that could support a healthy lifestyle, like healthy eating and a local free vitamin service. The service also encouraged recycling and had won an award for this work, with their certificate on display.

Staff developed plans for care for families. These were called therapeutic contracts. We saw that these included detailed information about the views, wishes and goals of

the parents. Therapeutic contracts were personalised and orientated towards the goals of the individual families. Staff and parents updated the contracts at regular intervals throughout treatment, in line with the operational policy for the service.

Staff shared the therapeutic contracts with families who wanted to have a copy.

Staff were required to record daily clinical notes, which we saw completed in a timely way. The service manager outlined to staff these should be clear but brief, to ensure staff had maximum available time to be engaging with patients.

At the last inspection in May 2016, we found that staff did not always upload documents about care in a timely way. During this inspection, this was no longer the case. Staff had dedicated time each week in order to do this.

Best practice in treatment and care

The service delivered interventions in line with a mentalization-based treatment (MBT) approach. This is recommended by the National Institute for Health and Care Excellence (NICE) for the treatment of people with a diagnosis or symptoms of borderline personality disorder. Care was delivered within the frequency and time period recommended by NICE. Parents had one-to-one MBT sessions with their named therapist each week and attended a weekly parent-focused therapy group and adult-focussed group. The adult-focussed group concentrated on parents' personal emotions and relationships. As part of treatment, parents also took part in filmed play sessions and attachment-based parent-child work.

Staff used recognised rating scales to rate severity and to monitor outcomes. These included measures of child development, parental reflective functioning and parental mental health. The service employed a research officer to complete these rating scales at regular intervals with parents. The research officer also carried out audits and produced anonymised reports demonstrating service outcomes over time. Staff explained parents' rights to opt-out of taking part in these if they wanted to. In the most recent report, outcomes demonstrated the fluctuation of parent's level of depression, stress and reflective functioning over the treatment time. Outcomes were also used with children and showed that over the time, children's abilities in receptive communication, expressive

Community-based mental health services for adults of working age

communication, fine and gross motor development increased. A small sample also showed that over time, children's difficulties such as conduct problems and hyperactivity decreased.

At the last inspection in May 2016, we identified that staff did not complete regular clinical audits, which could be used for benchmarking and quality improvement. During this inspection, we saw that staff now carried out an audit of incidents relating to safeguarding. This was used to identify patterns over time and identify improvements they could make, but was also reported to the overall provider so they had oversight of incidents. The audit included an action plan for staff to follow where necessary. For example, the most recent audit of forms identified staff needed to more consistently record the date the incident took place as well as the date it was reported, even if these were the same. Staff were not involved in any other audits, for example case note or risk assessment audits. This would allow senior staff to be assured of quality of recording. For example, identify if staff were completing all mandatory areas in patient notes, such as patient ethnicity.

Parents we spoke with said the service was helpful and a nice place, where staff understood individual family situations. They said there was a lot of therapy offered to support people to work on their relationships with others.

Records included a signed consent form for each parent involved in treatment. It was made clear in notes that patients were informed that they could withdraw from treatment at any time.

Skilled staff to deliver care

The clinical team included a clinical service manager and three therapists who were qualified clinical psychologists or social workers. To support this team, two project leads provided input one day a week. One project lead was a senior family therapist, and one was a consultant psychiatrist. Alongside the clinical team, the service employed a programme coordinator, a research officer and an intern. Several volunteer childcare assistants worked between four and seven hours a week on the two days that families attended the service. Their role was not clinical and was to provide care to children who needed intensive support and/or when parents were having one-to-one sessions with therapists.

Staff in the different roles were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group.

Managers provided new staff with an appropriate induction.

Managers provided staff with supervision. Staff met each week to discuss case management, to reflect on and learn from practice, and for personal support. Managers ensured that staff had access to regular team meetings.

All staff had had an appraisal in the last 12 months.

Multi-disciplinary and inter-agency team work

Staff held regular team meetings and supervision sessions to discuss patient care. Staff knew patients well as it was a small team, with a maximum of 10 families being part of treatment.

Staff had effective working relationships, including the sharing of safeguarding information and actions, with external organisations involved in patient care. This included social workers from the local authority.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

The service did not support people detained under the Mental Health Act (MHA). Training in this area was therefore not mandatory. Staff understood which external services as well as senior staff from the provider to contact if they identified that a parent may need additional mental health support outside of what this service delivered. Where a patient was being supported by an NHS mental health community team, staff were aware of this and communicated with this team where necessary and appropriate.

Good practice in applying the Mental Capacity Act

Staff received training in the Mental Capacity Act 2005 as part of their level two safeguarding training, which all staff had completed.

The service did not work with patients who would be subject to Deprivation of Liberty Safeguards.

Patients signed consent to treatment forms and these were stored in an accessible format in patient records.

Any children involved in treatment were under five years old and staff applied parental consent appropriately.

Community-based mental health services for adults of working age

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

Good 

Kindness, dignity, respect and support

We spoke with four parents and they said staff were supportive and helped them understand their own emotions and their partner's needs. One person said staff were straightforward, upfront and honest, which was good. Two parents described the service as brilliant, although at times stressful. Parents said they could see where the service had helped them move forwards in certain areas.

One parent said the volunteer childminders were a brilliant resource and excellent at looking after the children, especially when parents were finding therapy sessions challenging.

Staff attitudes and behaviours when interacting with patients showed that they were respectful and responsive to the needs of both parents and of children. Patients we spoke with said they felt staff listened to them completely. They said staff had a very good understanding of how parents may feel and react in certain situations, which helped everyone manage outbursts and helped them find new skills to manage their own emotions.

Records showed staff supported patients to be involved in, understand and manage their own treatment.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards or from patients without fear of the consequences. Where this had occurred, staff gave examples of how this was well handled by the service manager. If necessary, discussions in group therapy with patients took place to outline what kind of language was acceptable. Staff could also discuss incidents of discriminatory language in individual and group supervision. Staff we spoke with said they felt supported in this and said the service addressed this well with parents.

Staff maintained confidentiality of information about patients, but made it clear from the start that they were required to provide regular feedback to the local authority

about parents' progress or any issues in relation to risk to the child. Parents we spoke with had a clear understanding of this and were involved in some joint meetings with their keyworker and social worker from the local authority.

The involvement of people in the care they receive

Involvement of patients

Staff involved patients in care planning and risk assessment. Once therapeutic contracts were agreed by parents and staff, parents could have a paper copy to take home if they wished to. Staff and patients completed goal-based outcomes to measure whether patients felt they had come close to reaching their goals over the course of the 18 months. Data from discharge patients showed that patients felt they were closer to reaching their goals by the end of their treatment.

Staff communicated regularly with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties.

Staff enabled patients to give feedback on the service they received via regular surveys. These included questions about being understood, being spoken to respectfully and having treatment explained well. Between March 2017 and March 2018, 10 parents had completed evaluation forms. Five were all or mostly positive. Where patients answered negatively, it was about individual issues, such as not being given a clear date for review. Two patients noted that staff could have a better understanding of their culture. Data collected between 2011 and 2017 showed that on average, patients scored their satisfaction with services positively, with satisfaction increasing over time.

Staff ensured that patients could access advocacy and there was information on how to do this at the service. There was no record of staff verbally explaining to patients what advocacy services could offer, which may have been helpful. An advocate is someone who works independently of the provider and can help patients have their view and voices heard and support them to be involved in decisions about their care.

Are community-based mental health services for adults of working age responsive to people's needs?

Community-based mental health services for adults of working age

(for example, to feedback?)

Good 

Access and discharge

The service had clear criteria for which patients would be offered a service. The unit received referrals from social workers based in London boroughs. The service did not accept referrals from long distances as families were expected to travel to the unit twice a week over an 18 month period. Over a period of 12 weeks, staff assessed parents for their capacity to engage and to change. After this time, staff made a decision on whether the parents would benefit from being offered the 18 month programme.

There was no waiting list and families were seen for an initial meeting to discuss referral within a maximum of 14 days from referral unless delayed by court proceedings.

At the beginning of treatment, the service offered transport to and from the service to those families that needed it. The service recognised that patients may need extra support introducing regular structure to their week and identified this as a way to support them to access services.

The programme outlined that parents must attend 75% of the therapeutic programme over the 18 months. If they did not attend sessions, staff contacted them by phone to find out why. If necessary, a meeting with the parent, social worker and staff at the unit would be arranged to discuss how to better support the parent to attend.

At the end of the 18 months, families were discharged with an offer of up to six individual or couple sessions as follow up care. There was also a leavers group that parents could attend each month at the service after they had been discharged. The keyworker for the family was responsible for providing a written report for the local authority, which included the views of parents about their progress. Records showed staff discussed discharge with patients in the months before their treatment was coming to an end.

The facilities promote recovery, comfort, dignity and confidentiality

The service had a range of rooms to support treatment and care. For example, a communal kitchen and dining room, a large playroom, a group therapy room and two smaller

therapy rooms. There were two bathrooms for staff and patients to use, one bathroom for children and an accessible bathroom with a shower. The service had two separated garden areas, one for children to play and one smaller area that could be used as a smoking area. There were baby changing facilities and spare nappies and clothes available to parents if needed.

Patients said the environment was very welcoming and always kept clean and tidy.

The environment was light and welcoming and there were pictures of families on the wall. Throughout treatment staff and parents took pictures of individual families who wished to have them and presented them all together in a picture book at the end of the 18 months.

The kitchen was available for families to bring in their own food to prepare lunch if they wanted to.

There were lockers that families could use if they wanted or needed to during the day.

The children's playroom was large and had a lot of toys for the children to play with. Parents said it was a nice environment for their child to play.

Feedback from parents was that it would be helpful for there to be a quiet area for their children to nap during the day. Currently, staff offices were sometimes used for this. The clinical service manager said they were aware of this and there were plans in place to create a separate area off the playroom where children could nap.

Rooms were centrally heated, but some also had additional electric heaters. Staff said this was because some parents could have difficulty regulating their own temperatures, so these additional heaters could be used if needed to make them more comfortable.

Meeting the needs of all people who use the service

The service made adjustments for disabled patients. The service was accessible from street level and had an accessible bathroom.

Staff ensured that patients could obtain information about the service, patients' rights and leaflets were available. Where patients wanted this in another language, staff were able to provide this.

Community-based mental health services for adults of working age

The service was unable to offer treatment to people who could not speak English. Although this was made clear to referrers, it meant some people who may benefit from the service were unable to access it.

Listening to and learning from concerns and complaints

Patients knew how to complain or raise concerns. If patients complained or raised concerns, they received feedback from staff about how it was being managed and any outcomes. Information about how to complain was available on notice boards. During the inspection, we saw staff were open to receiving feedback and were skilled at speaking with patients who were unhappy with something.

One of the project leads ran a session every two months with parents to gather feedback from them about their treatment and also to discuss and respond to any concerns they had. This allowed parents a space to give feedback when therapy staff were not present.

At the last inspection in May 2016, feedback from patients was that complaints were not always recorded formally, and some people were unsure of the formal process. During this inspection, the four patients we spoke with confirmed this was now clear.

Staff knew how to handle complaints appropriately. There had been no formal complaints in the last 12 months, but staff kept a record of informal complaints or feedback in the case notes for each family. The staff tried to address and feedback or concerns immediately with patients, and we saw this taking place on the day of inspection. We found that staff responded to all feedback or informal complaints in a timely way.

The overall provider had recognised that there was no mechanism for patients to request an independent review of complaints if they were unhappy with the initial investigation outcome from a formal complaint. Senior staff were considering how to address this at the time of inspection.

There was information about advocacy services on noticeboards at the service.

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

Leadership

Leaders had been in post for a number of years and had the skills, knowledge and experience to perform their roles. Staff in leadership positions supported their teams through regular supervision and reflection to understand the vision, values and strategy for the service and demonstrated a detailed understanding of the services they managed. They could explain clearly how the team was working to provide high quality, specialist care.

Leaders were visible in the service and patients and staff said they were approachable. The clinical service manager was present at the service at all times and was involved in therapy sessions with patients as well as supporting the supervision and development of staff. The project leads would attend the service at regular intervals to meet with patients and were available to staff at all times.

As the team was small, there was limited availability for leadership development opportunities, but staff were aware of this.

Vision and strategy

The provider had a vision that it made clear to all staff and patients. It was to promote resilience and wellbeing in children, young people and families and contribute to a world where children and families are supported effectively to build on their strengths and to achieve their goals in life. This was communicated to staff throughout the recruitment process and ongoing training and support. We saw during the inspection that staff worked together to reach for this goal. The development of the Early Years Parenting Unit was an example of how the provider had taken a step to improve the quality, accessibility and effectiveness in treatment for more people.

Staff had the opportunity to contribute to discussions about the strategy for their service. For example, being involved in discussions about whether the amount of days a week that treatment was delivered was meeting the needs of the patients.

Staff could explain how they were working to deliver high quality care within the commissioning arrangements.

Culture

Community-based mental health services for adults of working age

The organisation had a culture of supporting staff through a supervision, training and appraisal framework. This included dealing with staff performance, discussions about career development and providing ample time and space for reflective practice and learning. Staff said they felt positive and proud about working for the provider and within their team. The service's staff sickness and absence rates were low. No staff reported experiences of bullying and harassment.

Staff said they felt respected, supported and valued by colleagues and by managers. They said they felt able to raise concerns without fear of retribution and had opportunities to discuss any areas of concern or feedback in staff reflective sessions. The provider had a whistle-blowing process that all staff were made aware of at induction. The manager had the skills and support to deal with poor staff performance if needed.

Governance

There were strong governance systems in place to allow the service manager to ensure a safe and effective service. There were systems and procedures to ensure that the premises were safe and clean; there were enough staff; staff were trained and supervised; patients were assessed and treated well, with treatment based on national guidance; incidents were reported and learned from.

There was a clear framework of what must be discussed at a team level in meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

Since the last inspection, the provider, service manager and team had worked well to address several areas of recommendation from our last inspection. They had made effective action plans and successfully achieved each point. This included increasing mandatory training courses, ensuring all staff had up-to-date criminal records checks and the process to report and respond to safeguarding was strongly embedded.

Staff had introduced clinical audit into practice and had scope to develop this even more.

Staff very clearly understood arrangements for working with other teams, both within the provider and external, to meet the needs of the patients. This was explained well to patients.

Management of risk, issues and performance

Staff at all levels were aware of the risks involving the families at the service and how to identify and manage these using the recording and reporting processes in place. For example, through a thorough assessment process and risk assessment, staff were aware of the individual risks and needs of each family, both the parents and the children. They had been trained in safeguarding and had dedicated time to discuss and record any concerns in clinical notes. These concerns would then be shared with the local authority of appropriate and management plans put in place to reduce the risks.

The service manager was in regular contact with the senior leadership team for the provider and shared all risks that needed to be escalated. This included clinical risks as well as those involving the environment or general service management.

Information management

The provider used systems to collect information and data that were not over-burdensome for frontline staff. For example, the research officer had clear timelines for collecting different outcome measures and clinical staff had dedicated time each week to write up notes from clinical work.

Staff had access to the equipment and information technology needed to do their work. Staff had highlighted that there were occasional connectivity issues and this was being addressed by the senior management team at the time of inspection. This had been escalated and responded to quickly.

Information governance systems included confidentiality of patient records. There was no patient information on display during our inspection.

The clinical service manager had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. They met with staff regularly and there were clear records available about risks and plans for care. Human resources staff for the overall provider could supply up-to-date information about staff training needs.

The service made notifications to external bodies as needed, including the Care Quality Commission.

Engagement

Community-based mental health services for adults of working age

Patients and carers had opportunities to give feedback on the service through questionnaires and face to face meetings with the project lead. Questionnaires were collated and audited regularly. Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.

Patients and staff could meet with members of the provider's senior leadership team to give feedback about services.

Staff we spoke with said they were able to access a lot of training through the main provider, which was helpful for their role and for their development. Staff said managers actively encouraged them to attend training.

Learning, continuous improvement and innovation

The service was initially set up in 2011 as an innovative service to deliver mentalization-based therapy to patients with personality difficulties who had young children. The treatment frequency and length was based on national guidance and the service has used regular outcome measures to demonstrate effectiveness and outcomes.

The service was small so did not have formal quality improvement projects, but staff said they could bring up ideas in team meetings and these would be acknowledged and acted upon.

As the service was specialist, there were no accreditation schemes that they could take part in, but the provider had input from trustees with backgrounds in peer review and accreditation schemes.

Outstanding practice and areas for improvement

Outstanding practice

The service employed a research officer who was responsible for completing outcomes measures with parents at regular intervals and producing outcome reports and audits.

The service offered transport to and from the service for newly referred families as a way to introduce and

encourage structure and ensure they could attend the two days a week required. The service identified a chaotic lifestyle as a potential barrier to access, and offered transport as a way to address this.

Areas for improvement

Action the provider SHOULD take to improve

The provider should ensure they continue plans to create a quiet space for children to nap during the day.

The provider should continue their work into developing a regular audit cycle, to ensure quality assurance and areas for improvement are identified.

The provider should ensure they consider how best to support patients to access an independent review of complaints.

The provider should ensure they work alongside the local authority and/or commissioners to consider the accessibility of the service to people who have language or communication barriers.