Private Psychiatry LLP

Orchard House

Inspection report

High Street
Leigh
Tonbridge
Kent
TN11 8RH
Tel: 01732 836320
Website: www.privatepsychiatry.co.uk

Date of inspection visit: 12 November 2018
Date of publication: 26/04/2019

Overall summary

We carried out an announced comprehensive inspection on 12 November 2018 to ask the service the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this service was not providing safe care in accordance with the relevant regulations.

Are services effective?

We found that this service was not providing effective care in accordance with the relevant regulations.

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this service was providing responsive care in accordance with the relevant regulations.

Are services well-led?

We found that this service was not providing well-led care in accordance with the relevant regulations.

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The service provides private psychiatric and psychological treatments for people experiencing mental health problems.

Dr Adrian Winbow is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Our key findings were:

We identified regulations that were not being met and the provider must**:**

- Ensure they have completed an environmental risk assessment to ensure the safety of their premises for patients, staff and those living at Orchard House.
- Ensure they use a recognised risk assessment tool to fully assess, monitor and mitigate patient risk consistently.
- Ensure clinical documentation is kept updated to reflect patients' risks and action taken.

Summary of findings

- Ensure risk management and crisis plans are specific to people's individual needs or presenting risks.
- Ensure they have systems, policy and processes in place for reporting, investigating, sharing and learning from incidents.
- Ensure they have systems and process in place to ensure they can deliver, monitor, review improve care and treatment.
- Ensure they have a system in place to monitor and limit prescribing of medicines that have the potential to be misused.
- Ensure all staff providing care or treatment to patients including children and young adults are competent, skilled and experienced to do so safely. This includes identifying any required mandatory training for staff to complete and discuss with them their learning needs.
- Ensure they coordinate care and communicate with the community mental health teams where required.

You can see full details of the regulations not being met at the end of this report.

There were areas where the provider could make improvements and should:

- Review their policies, ensuring they are comprehensive, up-to-date and accessible to all staff.
- Review and operate a robust system to highlight and manage vulnerable patients. This should include documentation on the patients' care records.
- Review and operate systems for managing infection control, ensuring they have a policy in place and identify a lead at the service.
- Review and operate systems to ensure they engage with GPs with regards to patients' ongoing physical health monitoring and ensuring they receive all test results requested.
- Review and operate systems and process to mitigate and review when patients decline consent to share information.
- Review and operate systems in respect of lone working.
- Review and operate systems that ensure covering consultants have up-to-date access to all patient records receiving care and treatment at the service.
- Review and operate systems to monitor the number of patients on their caseloads to ensure they can respond to patients' changing needs and prioritise urgent contact with patients where required.
- Review and operate systems to ensure they assess and monitor patients' physical health needs, and liaise with all appropriate health professionals needed. Assessments and care records should reflect this.
- Review and ensure assessments are holistic and consider patients' social and emotional needs.
- Review patients' crisis/contingency plans and ensure they are individual to their needs, they understand what to do in a clinical emergency and records reflect this.
- Review and ensure all patient records are kept up-to-date and are an accurate reflection of discussions had and care and treatment provided.
- Review and ensure the consultants receive continued professional development to support knowledge when treating young people.

Dr Paul Lelliott

Deputy Chief Inspector of Hospitals (lead for mental health)

Orchard House

Detailed findings

Background to this inspection

Orchard House is a stand-alone service for private, fee-paying patients run by Private Psychiatry Limited Liability Partnership.

The service is run by Dr Adrian Winbow who has over 30 years' experience as a general adult consultant psychiatrist within the NHS and private sectors. He specialises in treatment for a range of disorders including anxiety and phobias, alcohol misuse and addictions, eating disorders and psychotic and personality disorders. The service is provided for adults and young people over the age of 16 years old. The overall objective is to offer psychiatric and psychological treatments to people with mental health conditions in Kent, London and Surrey. Therapies are delivered on a one-to-one basis.

Working in partnership with Dr Winbow, is Professor Anthony Hale. Professor Hale is a general adult and forensic consultant psychiatrist with over 30 years' experience working in the NHS, including as medical director for two trusts. Professor Hale is also a lecturer at one of the local universities.

Alex Monk worked in co-operation with the service is a registered integrative arts psychotherapist, based in London and has experience of working in the NHS and private sector. The staff team is supported by three medical secretaries, a practice manager and a marketing manager.

The consultant psychiatrist carries out an initial assessment of all patients and a treatment plan is developed in consultation with the patient. All treatments provided by the service are evidence-based and include medication and psycho-social interventions such as mindfulness and cognitive behavioural therapy. The service also takes on medico legal work for people who require assessments for mental capacity and occupational health assessments as well as expert witness services.

The service address is:

Orchard House, High Street, Leigh, Tonbridge, Kent, TN11 8RH.

The opening hours for the service are mostly Monday-Friday 9am-5pm with some additional clinics held as needed. The service offers appointments at several locations in Kent, London and Surrey and clinic times vary. We did not visit these additional locations during our inspection and remained at Orchard House. The consultant lead for the service told us they also offered evening and weekend appointments to suit the needs of the patients.

We carried out an unannounced comprehensive inspection at Orchard House on 19 November 2018. Our inspection team comprised a CQC inspection manager, a CQC inspector and a CQC assistant inspector.

Before visiting, we reviewed a range of information we hold about the service, this included any notifications received and information submitted by the provider in the pre-inspection information request.

During our inspection visit we:

- reviewed nine patients' care records;
- looked at the environment at Orchard House and observed the interactions between the staff and patients during an appointment;
- spoke with four patients;
- spoke with five staff including the two consultants and three administrators;
- reviewed staff training records, governance documents, such as clinical governance meeting minutes, patients at risk and serious incident logs and clinical audits;

Detailed findings

- looked at policies, procedures and other documents relating to the running of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

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

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Safety systems and processes

- The service did not have clear systems to keep people safe and safeguarded from abuse.
- The provider had some safety policies in place which were accessible to all staff. However, we found some policies had not been reviewed and did not contain relevant, up-to-date guidance. On inspection, we found there were no dates or review dates on the policies we reviewed. However, following the inspection, the provider submitted a policy review schedule which had the names and dates of review for each policy. However, there was no policy for managing physical health and duty of candour. The policy for clinical risk screening was not adhered to by staff.
- No staff had received up to date safeguarding and work-place safety training appropriate for their role. For example, neither of the consultants were trained in level 3 safeguarding competencies which is a minimum for General Medical Council registered professionals. Staff we spoke with were not trained or competent in recognising safeguarding and did not know how to identify or report concerns. At the time of the inspection, and since registering with the Care Quality Commission in 2011, the provider had made zero safeguarding referrals to the local authority safeguarding. However, during the inspection we identified two cases where patients had been at potential risk of harm and/or abuse and a safeguarding referral should have been considered. There was no partnership working with any other agencies to help, protect or support patients who were/at risk of harm or abuse.
- The provider did operate a system to highlight vulnerable patients but this was not sufficient to manage the risks these patients presented. They had a 'risk register/log' where patients were RAG-rated in terms of their presenting risk and a summary as to what their risks were. This was reviewed by the provider at their monthly governance meeting. However, the risk register/log was not always kept up to date, there was no clear risk assessment tool being used to rate patients risks and the action taken to mitigate or remove risks was not always documented. We saw entries on the risk log that were incomplete and it was not clear what action had been taken following any reviews.
- The provider did not have a system to ensure vulnerable patients were highlighted on their records, that records were reflected the risks present and were easily identifiable. For example, patients on high risk medicines or at risk of abuse or harm. The providers policy stated a note would be put on the patients records so the consultant could easily identify at risk patients during appointments. However, because risk was not always identified or communicated to all staff, this was not done.
- All staff had the necessary Disclosure and Baring Service (DBS) checks completed to identify any previous criminal convictions. DBS checks identify if a person is on an official list of people barred from working in roles where they may come into contact with vulnerable adults and children.
- The provider did not have an infection control policy in place. There was no lead at the service for infection control. There were no hand washing posters displayed for people using the service or staff. However, we observed Orchard House was impeccably clean and very well maintained.
- The provider had not considered or completed an environmental risk assessment to ensure the safety of their premises for patients, staff and those living at Orchard House. There was no distinction in the environment between parts of the location used for clinical and domestic purposes. We found potential risks to patient safety including uneven floors, decorative glass ware, cleaning products and a steam iron ready for use. We were concerned that patients were accessing the service with risks unknown. We issued a warning notice to the provider because we felt this was a significant risk. We will follow this up at a future inspection to check the provider has acted and improvements have been made.

Risks to patients

- There were not systems to assess, monitor and manage risks to patient safety.
- The provider did not use a recognised risk assessment tool to assess and monitor risk consistently. Therefore, there was no evidence to demonstrate what areas of risk had been assessed. The consultants were responsible for all assessments relating to the patients care and treatment. We found they did not always fully assess patients risks to themselves or others or respond appropriately to mitigate such risks. We found a lack of

core assessments, risk assessments and mitigation of risks for patients. Clinical documentation was not always updated to reflect the patient's fluctuating risks. For example, risk information was difficult to locate in clinical notes. We reviewed nine care records and found treatment plans contained insufficient information and were not always updated to reflect changes to patient risk. The information recorded in patients' notes in respect of crisis/contingency plans was blanketed and the same in each of the nine records reviewed. Risk management and crisis plans were not specific to people's individual needs or presenting risks. We issued a warning notice to the provider because we felt this was a significant risk. We will follow this up at a future inspection to check the provider has acted and improvements have been made.

- The consultants communicated with the patients' GP or other primary care provider via letter, where consent to sharing information had been given by the patient. Of the nine records we reviewed, most contained detailed summaries to the GP explaining the outcome of assessments, treatment plan and diagnosis. The consultants would also write to the patient's GP to request blood tests be carried out when required. However, it was not always clear from patient records if the results from blood tests were communicated back to the consultant so they had up-to-date information and could monitor potential side effects of medicines prescribed or physical health conditions that may impact the prescribing of certain medicines.
- Where the patient had not given consent to sharing of information, there was no mitigation in place to manage the potential risk. For example, the consultants could not be assured that patients were not accessing the same prescribed medicines from their GP and their consultant at Orchard House.
- The provider reported no staff sick days in the 12 months prior to the inspection. We were informed the administrative staff covered for each other during periods of annual leave.
- All the staff working at the service had done so for many years, with three having had previous experience of working in health care. Although there was no formal induction system in place to support staff when they commenced their roles, all staff confirmed they felt well supported.
- The provider did not have a lone working policy in place to ensure the consultants' health, safety and welfare were protected. The consultants operated clinics across six locations, including Orchard House. Four of the locations were other hospital sites where they rented consultation rooms. Two of the locations were office style buildings.
- The administrative staff were aware of each of the consultant's availability and were responsible for scheduling appointments. When one of the consultants went on leave, we were informed in the case of an emergency the other consultant would cover. However, patient records were not all located at Orchard House, so the covering consultants' access to up-to-date records would not have been possible. However, following the inspection the provider told us consultants could access patients electronic records only. We were concerned that both consultants were working to full capacity with the number of patients they had on their caseloads and were not reassured that they would always be able to see patients in the event of an emergency.
- The provider did not assess or monitor the number of patients they could accept per consultant at the service. There was no mitigation in respect of the impact this could have on both the safety of the patients and staff. We were concerned about the provider's ability to respond to patients' changing risks and prioritise, especially when in a clinical emergency. For example, we found examples where patients had over a short period of time, made repeated calls to the service reporting a decline in their mental health and requesting urgent communication with the consultant. We spoke to the administrative staff who were the first point of contact for any patient. They told us when situations like this occurred, they would contact the consultant and inform them. They did not offer advice or signposting. If the consultant was on site but in an appointment with another patient, they would wait for the appointment to finish. If the consultant was off site, they would email or make phone contact. This meant there could be a delay in the consultant receiving the information and being able to respond appropriately. Consultants' calendars were back to back with appointments with little to no time to allow them to respond. The consultants told us they always ensured patients were aware what to do in an emergency, such

as seeing their GP, contacting the mental health crisis team or 999 emergency services. We did see one example where there had been a decline in the patient's mental health and the consultant helped support admission to an in-patient facility to ensure they received the appropriate care and treatment needed to protect and help them.

Information to deliver safe care and treatment

- Staff did not have the information they needed to deliver safe care and treatment to patients.
- Individual care records contained a one-page summary and treatment plan following the initial assessment, follow up letters to the GPs summarising the ongoing treatment and notes written by the consultants following consultations. We saw examples where the consultant had made referrals to specialist services. Records contained details of the patients' mental health needs but not their physical health needs. The provider told us they did not assess or monitor any patients' physical health needs as this was the responsibility of their GP.
- The consultants did not carry out any tests or examinations and would refer to other health professionals when required. We could see referrals frequently made to patients' GPs requesting blood tests but results from the tests were not always evident or documented in their care records. We spoke with staff who told us they often received test results back but this was also dependent on the GP. If no test results were received, the provider did not have a system in place to follow this up. This meant there was a risk information was not being communicated which could affect any ongoing treatment the consultant was providing.
- Care records were a mix of paper and electronic records. Not all paper records were stored at Orchard House. One of the consultants kept their patients records at their home. We were informed, as at Orchard House, all records were kept locked away in filling cabinets and a locked room. However, we could not confirm that was the case for the records stored off site from Orchard House as we were not able to inspect there. We were concerned that patients care records were not available to both consultants when providing cover for each other's patients. However, following the inspection the provider told us consultants could access patients electronic records only.
- Where the patient had given consent to sharing of information, the service shared information with their GPs and other relevant health care professionals such as psychotherapist to enable them to deliver safe care and treatment.

Safe and appropriate use of medicines

- The service did not have reliable systems for appropriate and safe prescribing of medicines.
- The service did not dispense or store medicines.
- The consultants prescribed medicine in line with current national guidance. Medicines were either prescribed by the consultant during the patient's appointment or via the GP, following communication from the consultant to the GP. However, this was dependent on the patient giving consent for the consultant to share information with their GP.
- The provider's prescription policy stated, patients requiring repeat prescriptions were required to be seen by their consultant in clinic and at intervals of no more than six months and a telephone consultant would not be sufficient. However, we reviewed nine sets of care records and found two examples where patients had only ever received telephone consultations or a recent in-patient admission and were regularly being prescribed medicines and were not being reviewed or fully assessed. Neither of the patients had consented to their information being shared with their GP and the provider had not considered the risk that patients may be getting prescriptions from their GP as well.
- The provider did monitor the general use of prescriptions. The service carried out an audit of prescribing which looked at the frequency and medicines being prescribed, as well as those that were controlled drugs. The provider's prescriptions policy stated 'regular' audits would be undertaken. Records given to us by the provider showed the last one had been carried out in 2016, with no concerns identified. However, the provider did not have a system in place to monitor and limit prescribing of medicines that had the potential to be misused. We saw examples where diazepam was prescribed over prolonged periods without any face-to-face contact with patients and were sharing of information with other health professionals had not been given. The risk of this was not considered or mitigated by the provider. We issued a warning notice

to the provider because we felt this was a significant risk. We will follow this up at a future inspection to check the provider has acted and improvements have been made.

- The consultants told us they would always inform patients about the risks, benefits and side effects of all medicines they prescribed. The providers policy stated this would be recorded in the patients notes. Records we looked at mostly documented this. Patients we spoke with also confirmed the consultants regularly discussed their medicines with them during appointments.
- The provider did not undertake any physical health or therapeutic drug monitoring. We spoke to the consultants about this who were not aware of the need to do so. The consultants spoke with patients about their medicines during appointments. We were told physical health monitoring remained the responsibility of the patient's GP. However, not all GPs were informed about drug treatment being prescribed as this depended on the patients consenting to their information being shared. Therefore, the GPs may not have been aware for the need of appropriate follow up or monitoring.
- Prescription pads at Orchard House were kept securely and accurate records were maintained. We were told prescription pads for controlled drugs were not carried by the consultants when operating from one of the satellite clinics due to risk of theft or loss.

Track record on safety

- The provider had not reported any serious incidents or near misses.

Lessons learned and improvements made

- The service did not always learn and make improvements when things went wrong.
- The provider did not have a policy for incident reporting. We spoke with staff and they were not aware of any process for reporting, sharing, investigating or learning from incidents. Staff told us incidents would be discussed during the monthly governance meeting. However, we were informed of one incident which related to the risk management of a patient and safety of the environment. There was no record of this having been discussed in the minutes of the meeting. When we spoke with staff about the incident they were not aware of it.
- We reviewed the minutes from the monthly governance meeting and could see attendance was variable. There were several occasions where one of the consultants did not attend. This meant safety issues were not always monitored, reviewed and communicated.
- There provider did not have a system for reviewing and investigating safety or safeguarding incidents or when things went wrong. They were not able to identify lessons learnt or themes to mitigate future risk or improve practice. For example, there had been some mortality incidents reported which involved patients who had been discharged from the service. The consultants supported at the coroner's inquest but did not carry out any internal learning reviews.
- The provider was not fully aware of the requirements of the Duty of Candour. The provider did not have a policy or system to support this. The service did not have systems in place for knowing about notifiable safety incidents. However, the provider encouraged a culture of openness and honesty and had not reported any incidents where by duty of candour would be applied.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

- Care and treatment was delivered in line with relevant and current evidenced based guidance and standards. For example, the consultant explained their reasons for choices of medicines prescribed.
- The assessments reviewed documented the patient's individual needs and preferences. The consultants completed a treatment summary which documented previous medical history, and explanation of the presenting concern and reason for appointment, diagnosis and very brief risk rating.
- We found that patients were not always assessed fully before treatment was delivered. For example, one patient who was prescribed medicines, had not been seen by a consultant for a face-to-face appointment and was only receiving telephone contact. We issued a warning notice to the provider because we felt this was a significant risk. We will follow this up at a future inspection to check the provider has acted and improvements have been made.
- Physical health screening and monitoring was not offered to patients. The assessment of patients' immediate and ongoing social and emotional needs was not always fully documented.
- The treatment summaries contained brief and generic details for what action a patient should take in the event of a crisis or emergency. Patients' we spoke with confirmed they were made aware from the point of their first appointment what the service could offer and where they could seek further help if their mental health condition deteriorated.
- Details of discussions in the appointment were sent to the patient via letter. The provider's policy stated treatment summaries and risk assessments should have been updated following a change in the individuals risk or clinical needs. However, from the nine records we reviewed we observed these were not updated since the first point of contact with the service.
- We saw no evidence of discrimination from the service when making decisions about care and treatment.
- To meet the demands of patients who could not always attend for face-to-face appointments, the service offered consultations via telephone. The service also gave out auditory recordings on mindfulness for patients to take home.
- One consultant worked with adults and young people. The consultant estimated that 10 percent of his work was with young people aged 16-18 years old. His staff team then provided information that Dr Winbow had treated 23 young people throughout 2018 (up until 20 November 2018). It was not clear how Dr Winbow was receiving ongoing professional development, training or support in relation to his care and treatment of young people.

Monitoring care and treatment

- We saw evidence to show that the consultants checked on the wellbeing of their patients at their appointments and changes to prescribed medicines were made where patients self-reported a need for there to be.
- Feedback from the patients we spoke with and from the providers own patient satisfaction survey demonstrated the service had a good reputation. Staff we spoke with told us they used this and the fact people kept coming back to show they were providing a good service.
- The provider did not formally collect or monitor information about people's care and treatment. This meant they did not know if the treatment and care provided was effective or appropriate for the individual's needs. For example, care records reviewed did not demonstrate that they provider used any tools such as anxiety or depression scales to see if patients were improving with treatment over time.

Effective staffing

- Both the consultants were appropriately medically qualified and registered with the General Medical Council and up-to-date with revalidation. They attended seminars and conferences that were of interest to them and relevant to their work. They also met with other consultants who were part of their peer group.
- The provider did not ensure all staff providing care or treatment to patients were competent, skilled and experienced to do so safely. The provider had not identified any required mandatory training for staff to complete or discussed with them their learning needs. None of the staff, including the consultants, had

completed any training in key areas of health and safety. We issued a warning notice to the provider because we felt this was a significant risk. We will follow this up at a future inspection to check the provider has acted and improvements have been made.

- The staff team at the service was small. Although the administrative did not receive formal supervision they all worked very closely with each other. All staff we spoke with told us they felt very well supported and informed. The consultants received peer support from other consultant psychiatrists.

Coordinating patient care and information sharing

- Staff worked well together but did not work well with other organisations, to deliver effective care and treatment.
- Patients mostly received coordinated care. The consultants referred to, and communicated effectively with, other services when appropriate. For example, we saw referrals to specialists for scans and regular communication with the patients GP when consent to share information had been given. The consultants gave the patient the option of receiving therapy such as Cognitive Behavioural Therapy and psychotherapy either directly with them or they referred them to other health professionals who could support this. However, we did not see any coordinated care or communication with the community mental health teams, for which some of the patients were also receiving care and treatment from. This meant patients could be receiving conflicting care and treatment across a number of services.
- The provider did not have a system to ensure that all test results requested by the consultant were received back. Tests were requested by the consultant via a letter to the appropriate health service and followed back up with the patient at their next appointment. Staff told us the GPs and other health care professionals would inform them of the test results which we did see evidence of in the patients' care records. However, we also found examples where results had not been received back and it appeared staff at the service had not followed this up.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history. This information was provided by the patients. This was discussed with the patient during their appointments. Patients we spoke with told us they were referred or signposted to other services if they were more appropriate for their needs.
- All patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP when they first attended the service. However, we did not see recorded in the notes this was discussed regularly with the patients to see if there had been a change. The onus was on the patient to raise this with the consultant.
- The provider had not identified medicines that were not suitable for prescribing if the patient did not give their consent to share information with their GP, or they were not registered with a GP. For example, medicines liable to abuse or misuse. Where patients agreed to share their information, we saw evidence of letters sent to their registered GP in line with GMC guidance.
- Care and treatment for patients in vulnerable circumstances was not coordinated with other services. For example, the provider did not communicate or work with the local authority safeguarding team to discuss potential incidents of abuse that may have required a referral.
- Patient information was shared appropriately (this included when patients moved to other professional services) if the patient had consented, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way via a letter sent by the consultant. However, there provider did not have clear and effective arrangements for following up on people who have been referred to other services. The onus was on the patient to feedback to the consultant or that of the treating services.

Supporting patients to live healthier lives

- Staff were mostly consistent and proactive in empowering patients, and supporting them to manage their own health and maximise their independence.
- Where appropriate, we saw staff gave people advice so they could self-care. For example, the consultant

promoted self-management to reduce symptoms related to stress and anxiety. The service provided auditory access to mindfulness so the patient could use skills at home.

- Patient risk factors were not always identified, highlighted to patients or where appropriate highlighted to their normal care provider for additional support. For example, the assessment of patients did not consider if they acted as a carer or were at risk of developing long term conditions related to their current health or due to medicines prescribed, such as obesity.
- Where patients' needs could not be met by the service, staff discussed this with the patient and redirected them to the appropriate service for their needs if they consented.

Consent to care and treatment

- The service obtained consent to care and treatment in line with legislation and guidance.
- The service obtained consent to care and treatment from all patients when first attending the service. Patients signed consent forms to share information with GPs for example, was recorded and kept in their files. The consultants understood the relevant consent and decision-making requirements of the legislation and guidance. However, there was not a clear record of any up-to-date training in respect of the Mental Capacity Act and Code of Practice for either of the consultants. The consultants told us they kept up with changes via conferences and through their doctor peer group. Where patients had not given consent for information sharing, such as communication with their GP about treatment being provided, this was not revisited with the patient at subsequent appointments to see if they had changed their mind.
- The consultants did not consider or record their justification to continue to treatment and prescription of medicines when a patient had declined to information sharing about their treatment with their GP or primary care provider. This was not in line with General Medical Council guidance.
- Prior to treatment commencing, staff made patients aware of the costs of receiving treatment at the service, including prescriptions, examinations and any tests that may be needed. The patients' options were explained to them including access to private care and what was available via the NHS. Where external treatment was required, the consultants offered to signpost patients to other care providers.
- None of the administration staff had undertaken any training in the mental capacity act. Staff we spoke with said it was not applicable to them as they had minimal patient contact and were not involved in any decisions about patient care and treatment.

Are services caring?

Our findings

Kindness, respect and compassion

- Staff treated patients with kindness, respect and compassion.
- The staff team were small, friendly and demonstrated a caring and respectful attitude towards all visitors to the service. Feedback from the patients direct to the service and those we spoke with confirmed this. All were very positive about each staff member and the way they were welcomed and received at the service. They spoke highly of both the consultants and the care and treatment received.
- Staff demonstrated an understanding or patients' personal, cultural and social needs. Many of the patients were well known to the team as they had been attending for treatment for some time. Patients we spoke with said they felt treated as individuals, their needs were understood and they never felt judged.
- The providers website clearly described what the service could offer. Patients confirmed they were well informed during their appointments with their consultant.
- Some patients reported that they liked the homely and welcoming facilities and the personal touch they received at Orchard House.

Involvement in decisions about care and treatment

- Staff helped patients to be involved in decisions about care and treatment.
- The consultants communicated well with the patients to support them to understand their care and treatment and diagnosis. Patients we spoke with confirmed this. They also told us the consultants gave them advice and they felt their needs and preferences were listened to. They felt involved in decisions about their care.
- The consultants recorded discussions about care and treatment needs with their patients and documented this in the patient's file. During the inspection, we found the detail recorded about discussions to be variable. We were only able to view records for one of the consultants. The other consultant's records were stored at his home and not at Orchard House.

Privacy and Dignity

- The service respected patients' privacy and dignity.
- The waiting room was located at the back of the house, away from the consultation room so conversations could not be heard. As soon as patients arrived, they were taken through to the waiting room. Patients and staff both confirmed they were not kept waiting long periods of time once arrived at the service. Because patients paid for the appointments, appointments did not overrun and patients had the waiting area to themselves. They were greeted on arrival by the administrative staff and the consultant came out to greet them when ready for their appointment to start.
- The service did not offer or carry out any personal examinations. Staff we spoke with confirmed patients often attended with family or friend support. The provider had not considered the possible need for a chaperone to support vulnerable patients who attended alone. The provider did not have a policy to support this and because of this no staff had received chaperone training.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- The service reflected the needs and choice of the patients. Patients were offered face-to-face and telephone consultations. Flexible appointment times were offered, including appointments on a Saturday. Patients could choose their appointment times and dates to suit their needs. Longer appointments were available where needed but as this was a paid for private service, this was at cost to the patient. Staff told us they were upfront and clear about the costs of care and treatment at the service.
- The facilities were very well decorated, comfortable and maintained. The consultation room was relaxing and pleasant. However, we were concerned about patient's privacy as people attending the service walked directly passed the windows and you could see directly into the room.
- There were multiple risks within the environment at Orchard House that the provider had not considered or identified which had the potential to affect the health, safety and welfare of patients accessing the service and staff.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. For example. Patients visiting the service who required wheelchair access could enter via a ramp at the back of the property. Staff told us they would also do their best to ensure individual needs could be met.

Timely access to the service

- Patients could access routine care and treatment from the service within an appropriate timescale for their needs.
- Patients had timely access to initial assessment, diagnosis and treatment. Staff told us they informed patients when accessing the service what the wait time for an appointment would be. However, the provider did not monitor performance such as referral to assessment times so it was unclear how long people were waiting to access the service. Patients we spoke with had did not report concerns about their access to see their consultant for treatment.
- Appointment times varied as did the locations from which the consultants held their clinics. Patients would often see their consultant at set times and days to suit their needs. Staff told us delays and cancellations of appointments were minimal and managed appropriately.
- Patients were charged for appointments. This included when they did not give enough notice to cancel or did not attend. Staff told us they were made aware of this when accessing the service. We also saw letters to the patient confirming when charges for non-attendance at appointments had been made and the reasons for this.
- The provider ensured they were upfront with costs for accessing the service and treatment and this was discussed with the patient. However, the provider did not screen patients' affordability and we did see examples where patients' finances meant they could not continue receiving care and treatment at the service and treatment had to stop until they could access services within the NHS. Staff told us there had also been cases where reduced fees had been charged to try and support patients.
- For patients who did not attend the or inform the service they would not be, staff told us they would telephone and see if they wanted to rebook another appointment. However, the provider did not have a policy or effective system to support and manage people who did not attend the service to ensure their health, welfare and safety. Staff told us minimal patients did not make contact.
- There consultants did not have capacity to schedule urgent appointments. They were often booked up in advance. We were concerned about how this was managed and how patients with an urgent clinical need were supported or signposted to other appropriate services.
- There was no out of hours cover. If patients required access to care when the service was closed they were signposted towards other services depending on the urgency and need.
- The provider did not have an effective system in place to ensure patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use and the staff were supportive helpful.
- Referrals for patients requiring additional support from other health care professionals were undertaken in a

Are services responsive to people's needs?

(for example, to feedback?)

timely way. We also saw examples where the consultants had supported patients with access to in-patient facilities when a decline in their mental health had necessitated the need.

Listening and learning from concerns and complaints

- Information about how to make a complaint or raise concerns was available in the patients guide which was accessible via the providers website and given to the patient at their first appointment. Patients could leave feedback via forms in the waiting room, email or via the providers website. Staff treated patients who made complaints compassionately.
- The service informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint.
- The service had a complaint policy in place. Complaints were discussed during the monthly governance meetings and learning was identified and changes to practice made.
- In the twelve months prior to the inspection the service had received three formal complaints which were responded to and dealt with immediately. Concerns related to a capacity assessment and storage of records. However, one relative told us they had tried to raise a concern about the service but had been told they would need to pay for a consultation in order to do this.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Our findings

Leadership capacity and capability

- The registered manager was in a limited liability partnership with another consultant. The service employed five administrative support staff which included a practice manager, marketing manager and three medical secretaries.
- The providers website showed that an integrative art psychotherapist was accessible to people using the service. The therapist was not directly employed by Private Psychiatry Limited Liability Partnership but was referred to as a team member in marketing information, staff data such as training records and on the service website.
- The day to day leadership of the service was mostly undertaken by the registered manager as he was on site most days whereas the other consultant worked predominantly from a number of satellite locations. The registered manager and his wife were highlighted as operational and financial management directors on the company's organigram.
- The registered manager had previously worked for the NHS until 1995.He had since worked in private practice and his work history included being medical director for a private hospital. The other consultant retained an NHS contract with a local NHS trust for one session per week which was used for teaching Cognitive Behavioural Therapy to trust staff.
- The registered manager understood the need to plan for the future leadership of the service.
- The two consultants were knowledgeable on the model of care and delivered clinical interventions which were evidence based and effective.

Vision and strategy

- Staff we spoke with expressed an overall aim to deliver excellent care and treatment to people using the service.
- One consultant spoke of potentially growing the business through mergers with other private psychiatry services.

Culture

- There was a culture of delivering in line with service user's expectations based on good customer care. However, there was lack of focus on delivering positive clinical outcomes underpinned by the lack of outcome measures, assessment tools or rating scales. The doctors judged outcomes on the basis of general satisfaction and the fact that they returned for future appointments.
- The registered manager spoke with pride about striving to deliver excellence. He told us that he saw it important to support the administrative staff so they could also deliver excellent care to people using the service.
- The administrative staff spoke of being happy in their work. They described the consultants as approachable and responsive if they had any concerns. The team only met monthly for the clinical governance meeting. There were no other team meetings to support a culture of teamwork.

Governance arrangements

- There were no clear responsibilities, roles and systems of accountability to support good governance and management.
- The registered manager led a monthly clinical governance meeting. We reviewed two sets of minutes of meetings held in February and May 2018.The minutes showed that attendance at the meeting was variable. All staff attended the February meeting but the May meeting consisted only of one of the consultants and the business manager.
- Service leads had not considered what the minimum standard of staff training needed to be. No staff had been trained in key areas of health and safety such as fire safety, safeguarding or information governance. This included the consultant psychiatrists. There was no expectation from the registered manager that staff would need to be trained in these areas. One consultant told us that staff did not need training as they only recruited highly experienced people. As most staff had worked for the service for several years, the training they had done in former organisations may no longer have been relevant or included key updates.
- Staff used a standard agenda within the clinical governance meeting that included risk assessment and management, medication, policies and procedures,

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

training and audits. However, minutes showed that there was limited depth and detail in the discussions at this meeting. For example, minutes detailed what training individual staff members had done since the last meeting but did not demonstrate any collective review of training needs or identify any arising actions. It was not clear from the minutes how these meetings contributed to quality governance in the service.

- The integrative art psychotherapist routinely attended the clinical governance meetings.
- The risk register highlighted that 'quality governance and risk management processes (were) not sufficiently understood and embedded within the organisation'. However, there were no corresponding actions in place to improve that.

Managing risks, issues and performance

- There was a lack of clarity around processes for managing risks, issues and performance.
- Both consultants reported that service users paying for further care and treatment was the main indicator that they were providing effective treatment with positive outcomes. During the inspection, service leads and the wider staff team could not provide basic details about the service such as the active caseload, percentage of young people and older adults being treated and the diagnostic profile of the people using the service. However, following the inspection the provider was able to submit this information.
- Risks were not shared and understood across the service. For example, we heard from one consultant that there had been an incident of service user agitation at one of the satellite clinics where the police had been called to assist. The other consultant was not familiar with the incident and said they had not discussed it though it was several months prior to our inspection.
- The risk register did not reflect the risks we found on inspection. The risk register was not unique to the service and did not detail any risks specific to people using the service. The risk register read as an overview of the service's aims and objectives rather than a meaningful way of reviewing key risks.
- Key risks were not noted on the risk register. For example, the risks associated with the service being based in a domestic dwelling were not documented on the risk register. Similarly, the risks of treating young people was not on the risk register even though it had been discussed regularly at the clinical governance meeting.
- Where service user risks were identified, service leads did not record any mitigating actions or date for review so it was not clear how the risk register contributed to positive risk management.

Appropriate and accurate information

- Quality and operational information was minimal and did not ensure and improve performance. The provider did not have a comprehensive clinical audit schedule to look at all required areas of care and treatment. Performance information relied almost entirely on the views of patient via feedback from their satisfaction survey. The service did have a good reputation and patients we spoke with were very pleased with the care and treatment they received.
- Quality and sustainability was occasionally discussed at their monthly governance meeting. However, from minutes reviewed, we saw meetings and attendance at meetings was variable. The provider told us about plans for future sustainability for the service including a possible merger with other professionals. However, patient capacity levels and sustainability for the consultants being able to take on more patients at the time of the inspection had not been considered.
- The provider did not always use information to monitor the performance of the service or ensure the quality of care provided. For example, prior to the inspection, staff did not audit the use of certain prescribed medicines that could have had the potential to be misused. Because the provider had not identified where improvement needed to be made, there were no plans to address this.
- The service did not submit data or notifications to external organisations as required. For example, potential referrals to the safeguarding team and statutory notifications to the Care Quality Commission. Staff did not understand their responsibilities for submitting notifications.
- At Orchard House, there were arrangements in line with data security standards for the availability, integrity and

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

confidentiality of patient identifiable data, records and data management systems. However, one of the consultants stored records off site at their home address and we could not confirm the same arrangements.

Engagement with patients, the public, staff and external partners

- The service advertised their business through their website. Most referrals were received through individual contacts, GP recommendations and from other sources such as counsellors and therapists.
- The service sought service user feedback on an annual basis through a satisfaction survey. We noted that the service received 100% positive feedback in their most recent survey.
- The views of staff, carers or other stakeholders were not routinely surveyed or used to improve the service.
- The two consultants did a newsletter for local GPs where they would submit papers in areas of interest such as personality disorder or medicines. The aim was to create additional revenue through this newsletter through GPs referring individuals to the service.

Continuous improvement and innovation

- Both consultants attended conferences and seminars as part of their continued professional development.
- During the inspection, we found little evidence of innovation and improvement. However, since the inspection the provider has demonstrated a commitment to improve the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (1) (2) (a) (b) (c) (f)**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The enforcement action we took:** We issued a warning notice to the provider on the 28 November 2018 and told them they must take action to improve by the 5 February 2019. **Regulation 12 (1)(2)(a)(b)(c)(d)**