Keats House

Quality Report

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

Overall summary

We do not rate sole practitioners.

We found the following areas of concern:

- The service did not have an embedded process to assess and record risks when patients were assessed at the service.
- Incidents were not being categorised and robust incident investigations were not taking place.
- There was no evidence that learning had taken place in response to serious incidents.
- The service did not always consult the patient's GP before prescribing medication.
- The service did not distinguish between serious and less serious incidents in the reporting of incidents onto its risk register.
- Safeguarding concerns and alerts were not being referred to the local authority.
- The service did not keep minutes of the consultant psychiatrist's supervision.
- The service did not integrate assessments into patient's care plans where appropriate.
- The service did not monitor the patients who self-discharged from the service without a discharge plan in place.

However:

- The service was delivered in a clean and comfortable environment which was accessible and welcoming.
- The service was well staffed and responded to patient needs in a prompt and flexible manner.
- The staff understood the duty of candour and gave examples of applying this duty.
- The service had a clear care pathway. The service was able to offer patients emergency appointments within a few days. There was no waiting list.
- Patients who used the service provided very positive feedback.

Summary of findings

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Summary of this inspection

Background to Keats House

Keats House has been providing community mental health services since 1999. It is a single practitioner service. Dr Pereira is a consultant psychiatrist who sees private patients referred to the service by their GP, by their employer or who are self referring. The practice consists of treating general psychiatric disorders including anxiety and depressive disorders. There are two rooms at the service, a consulting room and an administration office.

Keats House is registered to provide the following regulated activities:

Treatment of disease, disorder and injury

The service has not been previously inspected.

Our inspection team

The team that inspected the service comprised of two CQC inspectors and a specialist advisor who was a community consultant psychiatrist.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme. The inspection was announced.

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?

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited the service and looked at the quality of the environment
- spoke with three patients and had email contact with two patients who were using the service
- spoke with the consultant psychiatrist, practice manager and the two directors of the service (one of whom was the consultant psychiatrist)
- spoke with one other staff member
- spoke to two referring GPs and the pharmacist
- collected feedback from 52 patients using comment cards
- looked at 14 care and treatment records of patients, and

looked at a range of policies, procedures and other documents relating to the running of the service

Summary of this inspection

What people who use the service say

We collected 52 comment cards from patients who were currently using the service. All patients said that the service was very good. They said that the consultant psychiatrist was respectful and caring. They said that the staff were polite, discrete and accommodating. Patients found the consulting room and the waiting room clean, comfortable and welcoming. Patients were all impressed with the quality of the service they received.

We spoke with three patients and received emails from two patients who used the service. They spoke very highly of the consultant psychiatrist. They found it easy to make and amend appointments. They had referred other people to the service because they found it helpful.

We looked at feedback the service had collected from 20 patients who had used the service in the past year. The feedback was all positive. Patients found the consultant psychiatrist respectful, caring, effective and professional.

There had been no complaints during the previous 12 months.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not rate sole practitioners.

We found the following areas of concern:

- The service did not have an embedded process to assess and record risks when patients were assessed at the service.
- The service did not categorise serious and less serious incidents in the reporting of incidents onto its risk register.
- There was no evidence that learning had taken place in response to serious incidents.
- The service did not raise safeguarding alerts where necessary.

However:

- The service was delivered in a clean and comfortable environment which was accessible.
- The staff understood the duty of candour and gave examples of applying this duty.

Are services effective?

We do not rate sole practitioners.

We found the following areas of concern:

- The service did not always consult the patient's GP before prescribing medication, including the prescribing of controlled drugs.
- Care records were not clear and the use of assessments was not integrated into the care plan.
- The service did not ensure that the clinical notes were signed or had the consultant psychiatrist's name on them.
- There were no records demonstrating what had been covered in the consultant psychiatrist's supervision.

However:

- The consultant psychiatrist considered the physical healthcare needs of patients throughout their course of treatment. The consultant psychiatrist made referrals were made to specialists whenever this was appropriate.
- The service had strong links with psychotherapists delivering cognitive behavioural therapy and mindfulness and made referrals to these services for patients where appropriate.
- The consultant psychiatrist obtained consent from patients at the service in relation to contacting their family members and sharing information with GPs.

Summary of this inspection

Are services caring?

We do not rate sole practitioners.

We found the following areas of good practice:

- The staff were determined to provide the best quality service to patients. Patients said that staff were responsive, respectful, accommodating and did their best to make them feel listened to.
- The service had very positive feedback from patients who found the consultant caring, professional and effective. Patients felt that their emotional and social needs were very well supported by the consultant psychiatrist.
- The patients understood their care and the medication they were on. The consultant supported patients to come off of medication if they wished, and regularly referred patients to psychotherapy and groups sessions such as cognitive behavioural therapy and mindfulness therapy.
- Patients were active partners in their care.
- Patients said that the consultant psychiatrist researched their condition at length in order to understand their problems and provide the most appropriate treatment.

Are services responsive?

We do not rate sole practitioners.

We found the following areas of good practice:

- The service was able to respond to all calls from patients and referrers within 24 hours.
- The service was able to offer patients emergency appointments within a few days. There was no waiting list.
- Patients were able to contact the service out of hours and speak to a member of staff who would direct their enquiry to the consultant when necessary.
- GPs said that they could refer urgent cases easily to the service. Patients who were non-urgent were given an appointment within three weeks.
- The service was flexible, offering appointments in the evenings and on Saturdays. Appointments were rarely cancelled by the service. Appointments ran on time.

However:

- The service did not monitor the patients who self-discharged from the service without a discharge plan in place.

Are services well-led?

We do not rate sole practitioners.

Summary of this inspection

We found the following areas of concern:

- The service did not conduct independent investigations into serious incidents. This meant that there was no objective scrutiny of the service when things went wrong. This also meant that opportunities for the service to become more risk conscious were missed.
- Although there were systems in place to identify safeguarding and the provider ensured that staff had safeguarding training, the safeguarding system was not evaluated and monitored.

However:

- The staff had all been with the service for many years. There was no turnover and the sickness rate was low.
- The service had contingency plans in place to cover crises such as the consultant being unable to work for a long time.
- Staff were being supervised and appraised and were routinely completing mandatory training.

Detailed findings from this inspection

Community-based mental health services for adults of working age

Safe	
Effective	
Caring	
Responsive	
Well-led	

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

Safe and clean environment

- The environment was clean and well lit. The consulting room was welcoming and well decorated. The administrative office was spacious and had enough room for the members of staff who worked there.
- The service was on the ground floor of a communal building, which had different businesses and consultants operating from it. There was an intercom system at the front door to the building, which staff kept locked. There was a communal reception desk in the atrium, which had staff to help direct people to their destination. The receptionists controlled access to the building and could see who was coming in. There was a communal waiting room which was spacious, comfortable and clean.
- The consulting room and waiting areas were cleaned as part of the leasing arrangement for the premises.
- The consultant psychiatrist did not accept patients identified as being at high risk of self harm, suicide or violence. The consultation room at the service was not fitted with an alarm. However, the consultant psychiatrist's room was on the ground floor of a busy building with receptionists at the atrium leading to the consultant's room. The staff did not feel that there was a level of risk which necessitated an alarm. However, the service did not do a risk assessment regarding whether alarms were necessary or not. This meant that the service did not have oversight over the risk it was taking in regards to not having an alarm.
- There was a consulting room which had room for the consultant psychiatrist and patients and their family members or carers. The service did not have a clinic room and the consultant psychiatrist did not conduct physical health examinations at the service. The consultant psychiatrist corresponded with patients' GPs if they needed a physical examination or routine physical health checks.
- The environmental health and safety checks were done by an outside contractor, which was contracted by the building the service operated from. The contractor maintained the fire extinguishers, emergency lights and alarms. Information provided by the service showed that these were up to date and completed.

Safe staffing

- The service consisted of one consultant psychiatrist, a practice manager, a medical secretary and a personal assistant to the consultant psychiatrist. There was also a typist and a director who worked two days a week.
- The service did not routinely employ a consultant psychiatrist locum while the consultant psychiatrist was on leave. If the consultant psychiatrist was concerned about particular patients, a locum consultant psychiatrist was arranged to care for these patients while the consultant psychiatrist was on leave. This meant that patients had access to a locum consultant psychiatrist depending on their level of need if their regular consultant psychiatrist was on leave. The staff showed a clear understanding of the escalation procedure that they followed when a patient in distress contacted the service. This included contacting the service manager and the consultant psychiatrist and, if necessary, emergency services. The consultant psychiatrist was available by telephone while they were on leave and the staff gave examples of the rare occasion where they have contacted them while they were on leave.
- Sickness levels in the service were low. Two staff were sick for a total of six days last year.
- All staff who had contact with patients had enhanced disclosure and barring checks completed. Records

showed that staff had completed all mandatory training. This included children and adult safeguarding, health and safety, and information governance. There were supervision records for all staff and annual appraisals were all done.

Assessing and managing risk to patients and staff

- We reviewed 14 care records. There were summaries of risk in some patient files but these summaries did not address all presenting risks. The service had not developed a risk assessment template to be used with all patients, and there was no presence of systematic risk assessment taking place in clinical notes. Prior to the first appointment, patients were sent self assessments in the form of Becks anxiety inventory (BAI) and Becks depression inventory (BDI) to fill out before the initial appointment. Patient files contained the BAI and BDI but in the care records we reviewed, there was no clear written evidence in the clinical notes that they were discussed. This meant that the service did not demonstrate that they had reviewed risk with each patient.
- Patients referred to the service typically presented with mild to moderate mental health problems such as anxiety and depression. The service had not referred any patient to be detained under the Mental Health Act during the previous 12 months. Whilst staff viewed the risk profile of patients to be low, we found that some patients had complex needs and presented a high risk of harm to themselves . For example, two of the 14 care records concerned patients who had bipolar affective disorder, and one of these patients was prescribed lithium to manage their condition. One other patient had a recent history of self harm and attempted suicide. Three patients had died from suicide in the previous year.
- The service responded promptly to sudden deterioration in patients' health. If the administration staff in the service received a call from a patient that indicated that a patient's condition was deteriorating, they would contact the consultant psychiatrist immediately. The consultant psychiatrist would then arrange an appointment with the patient or speak to them on the telephone within a few days. When the consultant psychiatrist was on leave, they maintained telephone contact with the service and spoke to patients if necessary.
- The service had made no safeguarding alerts or raised any safeguarding concerns during the past year. However, when we looked at a care record, there was a disclosure of alleged harm done to a child within one of the clinical records. The consultant psychiatrist had not raised this as a safeguarding alert to the local authority safeguarding team. This was raised at the time of the inspection and the service made the safeguarding referral at that time. Another disclosure of abuse which was within a CQC notification of a death of a patient, had not been raised as a safeguarding alert at the time the disclosure was made.
- The service had a safeguarding policy and the consultant psychiatrist and staff were able to say what they would do if they had to raise a safeguarding concern. If staff were concerned about a patient's well-being, they would raise it with the consultant psychiatrist to make a decision on what to do next. The consultant psychiatrist would raise a safeguarding concern or alert with the local authority safeguarding team.

Track record on safety

- The service had recorded six incidents in the previous 12 months. The service did not categorise serious incidents and less serious incidents. The service recorded three incidents involving the suicide of a patient. One incident involved disruption to the email service. The other incident involved a report being sent to a GP in error.

Reporting incidents and learning from when things go wrong

- The practice manager completed a report when incidents occurred. We reviewed the records of incidents from the previous year. The details on the incident form were brief, usually limited to a single page report. The service did not use a recognised system based method, such as Root Cause Analysis, for conducting investigations. The consultant psychiatrist was the only clinician involved in investigations. The service did not commission independent investigations in response to serious incidents. This approach meant the level of scrutiny and objectivity of investigations was compromised. This, in turn, meant that opportunities for learning from serious incidents were limited. There was no evidence that learning had taken place in response to serious incidents. However, after the inspection, the service did make changes in response to recent serious

incidents. The service now include information regarding the consultant psychiatrist's admitting privileges to a private hospital, in all patient information leaflets and initial appointment letters.

- Three patients of the service had died from suicide within the previous 12 months. The consultant psychiatrist had written full reports for the coroners for the incidents which had been referred to a coroner's inquest. The service had reported these incidents to the Care Quality Commission.
- Some changes had been implemented following an non serious incident. For example, after a report was sent to a GP in error, staff were reminded to always check whether the patient had given consent before sending anything to GPs.
- The staff discussed incidents at clinical governance meetings. There had been three clinical governance meetings in the six months prior to the inspection. All the staff attended these meetings.
- There were no formal arrangements for supporting staff after serious incidents. However, staff at the service felt supported by their colleagues.

Duty of candour

- Staff and the consultant psychiatrist understood the duty of candour. For example, the service apologised to a patient when it sent a report to their GP in error. This duty was introduced in April 2015. It requires staff to provide people who use the service with reasonable support, truthful information and an apology when things go wrong.
- We saw evidence in care records that in one of the cases of suicide, the family was offered support from the service, referrals for grief counselling, and support for the children in the family. The consultant psychiatrist wrote letters of condolences to families of patients who had died.

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

(for example, treatment is effective)

Assessment of needs and planning of care

- At the initial consultation, the consultant psychiatrist and patient discussed the presenting concerns, the patient's psychiatric history, medical history, allergies, family history, social circumstances, lifestyle and current and previous use of drugs and alcohol.
- The consultant psychiatrist kept clinical notes of each consultation with a patient. We looked at 14 care records. The consultant psychiatrist did not write these notes in a way that could be clearly understood by other people. The notes did not consistently include relevant clinical findings, a record of decisions made and actions agreed, information given to patients, any drugs prescribed or other investigation or treatment, or details of who was making the record. However, the consultant psychiatrist wrote comprehensive letters to the patient's GP about the assessment and prescribing and copied in the patient. These letters provided a formal and comprehensive account of the consultation. They included a brief care plan, the medication prescribed, the diagnosis and any referrals made to psychotherapy. The consultant psychiatrist estimated that between 10% and 15% of patients did not consent to the service contacting their GP. For these patients, there was no clear, comprehensive record of the consultation and no detailed GP letter outlining the assessment.

Best practice in treatment and care

- The staff team comprised a consultant psychiatrist, a practice manager, a medical secretary and a personal assistant to the consultant psychiatrist. Two of the staff worked five days a week. The practice manager worked two days a week. The consultant psychiatrist worked six days a week. The service also had a typist who worked remotely two days a week, and a director who worked two days a week.
- The directors had taken action to reduce the workload of the personal assistant and the medical secretary. These included installing telephone answering system and additional typing resources. The consultant psychiatrist routinely consulted the patient's GP before prescribing medication. Care records contained an assessment of medication history from the patient's perspective. Referral letters from GPs contained a list of medication that the patient was currently using, as well as medication they previously were prescribed, if relevant. If the patient did not consent to their GP being consulted, or if their GP was in another country, then the consultant psychiatrist did not consult the patient's GP.

In two of the care records we saw, the consultant psychiatrist prescribed medication to the patient without first contacting the patient's GP. This meant that the consultant psychiatrist did not have full information about the patient's medical history and any current prescriptions the patient was receiving and posed a risk of overprescribing or risk of harm from medicines interactions.

- The service did a controlled medication prescription audit between July and December 2016. It showed that 18 patients were prescribed a controlled medication. The consultant psychiatrist prescribed controlled medications to three of these patients without first contacting the patients' GPs, who were all located out of the UK. This meant that the service did not have access to a recent medical assessment and medicines reconciliation was not done before the prescription of controlled medications.
- Before the initial appointment, the patient's GP sent a referral letter with the patient's medical and mental health history and a list of current medication. Where patients self referred to the service, this information was missing from the patient records. Prior to the first appointment, the patient was sent self-assessment rating scales to support the assessment and measure symptoms. These included Becks anxiety inventory (BAI) and Becks depression inventory (BDI). At the initial appointment, the psychiatrist assessed the patient and reviewed the BAI and BDI. After the assessment, the psychiatrist discussed with the patient whether medication would be needed, and if so, what the options were. After the medication was decided between the psychiatrist and the patient, the consultant psychiatrist discussed a referral to psychotherapy, including cognitive behavioural therapy and mindfulness. Then the consultant psychiatrist and patient agreed on a care plan, including changes to diet, exercise or other goals that the patient had. The consultant psychiatrist finished the initial appointment with an agreement with the patient as to how often the patient would visit the service to assess the effectiveness of the treatment plan.
- This care pathway was not always clearly evidenced in the patient care records. For example, if the patient had self-referred and had not given consent for the service to contact the GP, then there would be no referral letter with the patient's history or current medication. Patient files contained the BAI and BDI but there was no written evidence in the clinical notes that they were discussed. Clinical notes and patients' care plans did not consistently include relevant clinical findings, a record of decisions made and actions agreed or information given to patients.
- The consultant psychiatrist used the BAI and BDI to support their assessment. However in the 14 care records we reviewed, there was no mention of the results of these assessments in the clinical notes. Patients completed the BAI and BDI again after a period of treatment to measure their progress. The consultant psychiatrist also used the generalised anxiety disorder (GAD-7) assessment and patient health questionnaire (PHQ-9) assessment where appropriate.
- The consultant psychiatrist was the sole practitioner within the service. There were no other clinicians in the service who would need to read patient care notes. The consultant psychiatrist did not put their name or signature on the care records following a review or consultation with a patient. This posed a risk of not being able to accurately audit assessment and treatment decisions.
- When appropriate, the service provided letters to employers confirming that patients were medically unfit to attend work.
- The consultant psychiatrist considered the physical healthcare needs of patients throughout their course of treatment. Matters relating to physical healthcare were raised in letters to patients' GPs. The consultant psychiatrist made referrals were made to specialists whenever this was appropriate, such as sleep analysis.
- The consultant psychiatrist had monthly peer supervision with four other doctors who worked at other practices. During these monthly meetings they were able to bring up difficult cases and incidents involving patients. Notes of these meetings were not available to review on the inspection as meetings of the peer supervision sessions were not recorded.
- The service stored paper records of clinical notes and printed copies of letters to patients' GPs in a locked filing cabinet in the consulting room. The service held an electronic record of letters written and information relating to invoices on computer. Staff were required to input a personal password to access this information.

Skilled staff to deliver care

- The consultant psychiatrist was a sole practitioner. The consultant psychiatrist had the skills and qualifications

needed to carry out their role. The consultant psychiatrist had been revalidated by the GMC in the previous three months. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.

- The consultant psychiatrist had over 30 years of experience treating patients with mental health illnesses.
- An external psychiatrist supervised the psychiatrist monthly. Minutes of these supervision sessions were not available during the inspection. The consultant psychiatrist received appraisal from the Independent Doctors Federation every year. The most recent appraisal stated that the consultant psychiatrist was able to address any risks presented by being the sole practitioner by attending a peer support group and having regular contact with other psychiatrists who referred patients to the independent hospital the consultant psychiatrist had practicing privileges with.

Multi-disciplinary and inter-agency team work

- The staff met in November 2016, December 2016 and February 2017. At these meetings, the team reviewed regulatory compliance, the organisation's risk register, finance and administrative matters.
- The consultant psychiatrist had good communication with referring GPs and the doctors associated with large companies in the UK. In patient records there were clear and full letters to and from GPs, with patient medical and mental health history, a summary of mental health conditions and a list of current prescribed medication.
- We talked to two GPs who regularly referred patients to the service. They said the referral procedure was quick and straightforward. They found it easy to talk to the consultant psychiatrist. The GP said they would give a brief patient history and a list of current medications in the referral letter.
- We talked to the pharmacist who regularly dispensed the medicine prescribed by the service. The pharmacist said the prescriptions were easy to understand and clear as to why the medicine was being prescribed. If the pharmacy had a question, it was easy for them to contact the service for an answer. The pharmacy said that the patients of the service were well informed about the medication they were prescribed. They said that they prescribed twenty to thirty prescriptions a month to the patients of the service.
- The consultant psychiatrist received reports and updates on progress from psychotherapists who were involved in the care of the patient.
- The consultant psychiatrist had practicing privileges with an independent hospital. The consultant psychiatrist referred seven patients to an independent hospital for in-patient mental health care during the previous year. The consultant psychiatrist remained responsible for patients if they were in-patients at the independent hospital where they have practicing privileges.

Adherence to the MHA and the MHA Code of Practice

- There were no patients subject to the MHA receiving care or treatment at the service.
- The consultant psychiatrist had previously undergone comprehensive MHA training. The consultant psychiatrist had an appropriate knowledge of the MHA and code of practice and was aware of how to make a referral for a MHA assessment should it be required.

Good practice in applying the MCA

- The consultant psychiatrist understood their legal responsibilities in relation to obtaining consent from patients at the service. There were signed consent to share information forms in patient care records.

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

Kindness, dignity, respect and support

- Patients told us that the staff always treat them with kindness and respect. They felt that the staff went the extra mile to accommodate their preferences and wishes.
- Patients said that the consultant psychiatrist approached their care with sensitivity and discretion, they felt that they could bring up any concerns with the consultant psychiatrist. They felt that their emotional and social needs were well cared for and that the consultant psychiatrist was genuinely concerned about their well-being.
- Patients expressed gratitude for the support of the consultant psychiatrist. Patients had full confidence in the consultant psychiatrist's ability to help them get better.

Community-based mental health services for adults of working age

- In the comment cards received by the Care Quality Commission prior to the inspection, patients told us that the psychiatrist was able to look at their individual cases holistically and was able to offer appropriate options. Patients felt in control of their care, with the support of the service.
- Patients said that the consultant psychiatrist researched their condition at length in order to understand their problem and provide the most appropriate treatment.

The involvement of people in the care they receive

- Patients told us that they are fully involved in their care. Patients said that the consultant psychiatrist listened to them and fully explored options in care planning.
- Patients told us that they were supported to come off of psychotropic medication where appropriate. Patients said that they found the referrals to psychotherapy very helpful.
- Patients said that the advice that the consultant psychiatrist gave them was clear, relevant and helpful. The pharmacist we spoke to said that the patients of the service were well informed about the medication that the consultant psychiatrist prescribed them and understood why they were on medication.
- Patients told us that the staff were very professional and kind, they were able to cancel, amend or request emergency appointments easily. Patients found the service very person-centred and responsive.
- Patients we spoke with told us that they were able to bring their family members, including their children, to consultations.
- Care records showed that the consultant psychiatrist maintained regular contact with patients' families when patients were particularly unwell.
- The service collected written feedback from patients in the form of letters, cards and emails. We saw 20 examples of feedback collected during the previous year. The feedback was all very positive and patients thanked the consultant psychiatrist for the help and support that they had received. Some patients said that the consultant psychiatrist had helped them regain control over their lives.

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

(for example, to feedback?)

Access and discharge

- Referrals came directly from patients, the patients' GPs, or from the patients' employer.
- The consultant psychiatrist had a case load of 750 patients at the time of the inspection. The service took on average 25 new referrals a month. The service kept two or three consultation sessions free every week to ensure that urgent referrals were seen within a few days of referral. None urgent referrals were seen within three weeks.
- Not all patients required regular monthly appointments. Some patients were seen every six months to update on the progress of the referrals made to psychotherapy and to monitor the effectiveness of medication. This meant that the frequency of reviews by the consultant psychiatrist depended on individual needs.
- During 2016, the service saw 745 patients and received 294 new referrals. During the month before the inspection, the service held 215 consultations.
- The service did not hold a waiting list of patients.
- The consultant psychiatrist managed and reassessed the caseload according to the individual clinical needs of patients.
- Outside of office hours, patients contacted the medical secretary or the personal assistant who would pass on information to the consultant psychiatrist. The consultant psychiatrist remained in contact with the service while on leave.
- The service did not have clear criteria for referral and admission to the service. However, most referrals were made by GPs based on in the knowledge of the consultant psychiatrist's expertise in depression and anxiety.
- The service did not keep a record of patients who disengaged from the service without a formal discharge plan in place. If the service knew the patient was unwell and therefore not contacting the service, the consultant psychiatrist stayed in contact with the patient's family and advise them to call emergency services if the patient became very unwell.
- The practice tried to engage patients who were classified as 'unplanned discharge', but as a private practice it was subject to patient choice and wishes. The personal assistant actively followed up patients

who disengaged, but the service was ultimately guided by patient choice and free will and choices they make regarding their future treatment and economic circumstances.
- The service responded to all contacts from patients, GPs and employers within 24 hours.
- The service worked mainly with adults of working age, however the service had accepted referrals for five people under the age of 18 in the previous year. These five people were all 17 at the time of their first consultation with the service.
- The service offered appointments between 8.00am and 8.00pm between Monday to Friday and between 9.00am and 5.00pm on Saturday.
- Staff and patients said that appointments were only cancelled if it was considered absolutely necessary and that appointments could be re-arranged. The service asked patients to give 48 hours' notice if they wished to cancel an appointment in order to avoid the service charging them for the appointment. Patients told us that appointments were never cancelled by the service.
- Staff and patients said that appointments ran on time.

The facilities promote recovery, comfort, dignity and confidentiality

- The consulting room was comfortable and spacious. There was room for patients' carers or family members to attend the consultation. There were hot and cold drinks available for people waiting for their appointments.

Meeting the needs of all people who use the service

- The reception and consulting room was accessible to people who had disabilities. There were toilets available in the common area of the building, but these were not accessible to people with disabilities.
- The service accessed translators for people whose first language was not English.
- The service provided appointments after work and on weekends to accommodate patients who worked.

Listening to and learning from concerns and complaints

- Patients we spoke with said that they knew how to complain. There had been no complaints from patients or referrers in the previous 12 months.
- The service stated that if there was a complaint about the environment, the complaint would be referred to the Directors for the building who oversaw the maintenance and cleanliness of the building and rooms. The service stated that if there was a complaint about the service itself, it would be addressed by the practice manager and logged onto the risk register. The risk register would indicate what actions needed to be done to address the complaint and how to prevent it from happening again. The risk register was discussed at team meetings.

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

Vision and values

- The service was committed to achieving clinical excellence in mental health service provision. The staff reflected this vision in the responsiveness they had towards patients and referring GPs.

Good governance

- The service had an administrative framework to support the work of the psychiatrist. The service was able to coordinate the care and support of a large caseload of 750 patients and receive very positive feedback from patients and referring GPs.
- There had been three governance meetings in the previous six months. These meetings were minuted and had a standing agenda which included reviewing the risk register, compliance with CQC regulations, and finance.
- The service had staff who had worked with the consultant psychiatrist for many years; there was no turnover and the sickness rate was low. The team worked well with one another and were effective in providing what the patient wanted.
- The service had contingency plans in place to cover crises such as the consultant psychiatrist being unable to work for a long time as well as if the building was inaccessible due to flood or fire. For example, in the case of the consultant psychiatrist being unable to work, there were two named consultant psychiatrists who would take over the current caseload.
- There were no independent investigations of incidents. For example, when patients died from suicide, the service did not complete a root cause analysis. There

was no independent investigation into the incident. At the time of the inspection, there was no evidence of learning from these serious incidents, although there had been some changes to the service after the inspection to reflect learning from serious incidents.
- Although there were systems in place to identify safeguarding and the provider ensured that staff had safeguarding training, the safeguarding system was not evaluated and monitored.

Leadership, morale and staff engagement

- Staff worked extra hours during evenings and at weekends. All contacts to the service were responded to within 24 hours by the consultant psychiatrist or staff. The personal secretary and medical secretary would take it in turns to have their work phone always on at home to take calls from patients. The whole practice team (the consultant psychiatrist, the personal assistant, the medical secretary and the practice manager) were active on-line late and at weekends. This helped to provide a responsive level of service.
- Staff said that they enjoy their work and that they saw the team as part of their family.
- Staff have known each other for 10 years or more and got along well together.

Commitment to quality improvement and innovation

- The service recently started arranging the home delivery of prescriptions to patients who had difficulties in getting their prescriptions. These patients were living in areas which did not have a local pharmacist or who had difficulty leaving the house.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must assess the risks to the health and safety of patients.
- The provider must ensure the proper and safe management of medicines and liaise with patients' GP before prescribing medication.
- The provider must ensure there are appropriate systems for investigating serious incidents.
- The provider must ensure that learning takes place in response to serious incidents.
- The provider must ensure there are appropriate systems established and operated effectively to investigate abuse. The provider must raise safeguarding alerts when necessary.

Action the provider SHOULD take to improve

- The provider should ensure that notes are written in accordance with standard practice for registered medical practitioners. The provider should ensure that clinical notes are signed and have the consultant psychiatrist's name on them.
- The provider should ensure that minutes are kept of the consultant psychiatrist's supervision.
- The service should ensure that the use of assessments is integrated into patient's care plans where appropriate.
- The service should monitor the patients who self-discharged from the service without a discharge plan in place.
- The service should integrate exclusion criteria into the service, so that it is clear what acuity of patients are accepted into 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 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider was not assessing the risks to the health and safety of service users receiving the care or treatment. Risk assessments were not being carried out by the service. This was a breach of regulation 12 (2) (a) The provider was not ensuring the proper and safe management of medicines. The provider was prescribing medications without contacting patients' GPs for medicines reconciliation or physical health assessments. This was a breach of regulation 12 (1)(2)(g)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment There were no effective and established systems and processes to prevent abuse of service users.

This section is primarily information for the provider

Requirement notices

The provider was not raising safeguarding alerts where necessary.

This was a breach of Regulation 13 (2)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider was not effectively monitoring and mitigating the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. The provider did not have independent investigations into serious incidents. The provider did not ensure that learning was taking place following serious incidents. This was a breach of Regulation 17 (2)(b)