

# Psychiatry-UK LLP

## 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

### Ratings

#### Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive?

Good 

Are services well-led?

Good 

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

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

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

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

# Summary of findings

## Overall summary

### We rated Psychiatry UK as good because:

- Patients were respected and valued as individuals and empowered as partners in their care, practically and emotionally, by a distinctive service. Staff worked in partnership with patients and carers to provide the best treatment for them and acted on feedback from them and their carers to adjust their support. The provider created patient forums through which patients could feedback about their care and have access to peer support. We saw examples of how the service had responded to match the requirements of the patient group.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Patients told us that by having a consultation and a diagnosis with this provider, they could resume a fulfilling life due to having the correct medication prescribed. Feedback from commissioners and other services was consistently positive about the way the provider worked together with them to achieve the best outcomes for patients. Staff engaged in clinical audit to evaluate the quality of care they provided. The teams included or had access to the full range of specialists required to meet the needs of the patients. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation. Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- The service provided safe care. The number of patients on the caseload of the teams, and of individual members of staff, was not too high and staff could give each patient the time they needed. Staff managed appointments well to ensure that patients who required urgent care were seen promptly. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- The service was easy to access. Patients could choose a preferred psychiatrist by viewing their profile on the provider's website and could choose a preferred appointment time by viewing their calendar. Staff assessed and treated patients who required urgent care promptly and those who did not require urgent care did not wait too long to start treatment. Patients who had been waiting years for an appointment with other services received an appointment within a week with this provider. The criteria for referral to the service did not exclude patients who would have benefitted from care. The provider saw all patients initially before deciding if they could provide appropriate treatment.
- The service was well led and the governance processes ensured that procedures relating to the work of the service ran smoothly. The provider reacted quickly when they recognised that systems were not running as effectively as they could be. For example, they had recently appointed a chief technology officer to support improvements with their information technology systems. The provider engaged remote workers effectively and actively sought feedback to improve their service provision.

# Summary of findings

## Our judgements about each of the main services

### Service

**Community-based mental health services for adults of working age**

### Rating

Good



### Summary of each main service

Psychiatry-UK provides online consultations by tele-conference with psychiatrists and nurses to fee-paying and some NHS patients. They provide assessments and prescriptions.

# Summary of findings

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### Summary of this inspection

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Good 

# Psychiatry-UK LLP

## Services we looked at

Community-based mental health services for adults of working age

# Summary of this inspection

## Background to Psychiatry-UK LLP

Psychiatry-UK provide online services to patients via video conferencing, email and telephone.

Psychiatry-UK aims to provide easy access to a consultation with a psychiatrist and ongoing support from nurse prescribers.

Most patients who consulted the service suffer from depression, anxiety disorders, attention deficit hyperactivity disorder (ADHD), perinatal conditions and addictions. Most patients are adults with about 5% being children (age 10 and over). Half of the adults consulting the service did so for ADHD.

The service is provided to people who pay privately for it and some NHS patients where commissioning arrangements are in place.

The provider comprises a group of consultant psychiatrists who provide remote mental health advice, diagnosis of mental health conditions, prescriptions and information services. There are also a number of registered nurse prescribers who provide ongoing support to patients with their medication following their consultation with the psychiatrist.

Psychiatry-UK is registered with the information commissioner's office as a data controller.

Psychiatry-UK is registered with CQC to provide treatment of disease, disorder or injury. The service has a registered manager.

This was our second inspection of the service. During our last inspection in April 2018, we told the provider they must make improvements to:

- ensure it had measures in place to confirm the identity of patients before commencing consultations ensure it had appropriate safeguarding procedures in place
- ensure it had appropriate induction procedures in place for staff, monitor the quality of the work of staff and provide staff with supervision and appraisal
- ensure it had effective systems and processes in place to assess, monitor and improve the quality and safety of the service.

On this inspection we found that the provider had made all the required improvements.

## Our inspection team

The team that inspected the service comprised a CQC inspector, an inspection manager and a variety of specialists: a mental health nurse, pharmacist inspector and expert by experience.

## Why we carried out this inspection

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

## How we carried out this inspection

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

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

# Summary of this inspection

- Is it well-led?

Before the inspection visit, we reviewed information that we held about the provider, asked a range of other organisations for information and sought feedback from patients

During the inspection visit, the inspection team:

- spoke with eight patients who were using the service and one carer
- spoke with the registered manager, the chief operating officer and the business development manager
- spoke with five other staff members; including doctors, nurse prescribers and an administrative worker
- received feedback about the service from care co-ordinators and commissioners
- collected feedback from 30 patients using our 'share your feedback' website, 'iwantgreatcare' website and from the provider's website.
- looked at 10 care and treatment records of patients
- reviewed a sample of staff personnel files
- carried out a specific check of the medication management and prescribing practices and looked at a range of policies, procedures and other documents relating to the running of the service.

## What people who use the service say

Patients said that the referral and appointment booking process was quick and efficient, the administrative team were responsive and prescriptions were issued and delivered quickly.

Patients said the doctors were objective, non-judgemental, compassionate and experienced in all aspects of care.

They told us that they appreciated the additional support available to them whilst their medicine dose was adjusted. They told us the service provided them with support and adjustments such as signposting them to networks to support them physically, emotionally, financially and socially.

Patients said doctors were respectful, understanding, thorough, and most importantly explained things in a way that made sense and left them feeling empowered. They said they finally felt like they had someone who had listened to them and could not recommend the service highly enough and that staff had very good listening skills and their skills to evaluate every detail of what patients said was incredible.

Patients said that doctors went over and above their roles; for example, supporting them to compile letters for personal independent payment appeals.

Patients said the portal was easy to use and they liked being able to access everything in one place.

Those with attention deficit hyperactivity disorder (ADHD) appreciated that one of the founders of the company was a person with ADHD and that services had been formed from a patient's viewpoint.

One patient said the provider had saved their life as they were finally given a correct diagnosis; others said that the provider had literally changed their life beyond their expectations and that their consultation was one of the best patient experiences they've had in their lives.

Patients said the provider was incredibly well-led with good safeguarding practices and that they received a very clear and concise service. They said how responsive doctors had been with external providers such as schools and setting up care plans with external agencies.

Patients said that the provider's approach to their care seemed personalised to suit them and their needs. They were willing to adjust their treatment options according to their feedback. They also were very open to organising shared care agreements with patients' NHS GPs.

# Summary of this inspection

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Are services safe?

We rated safe as good because:

- The service had enough staff, who knew the patients and received basic training to keep patients safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.
- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. Staff followed good personal safety protocols.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to designated staff providing care.
- The service used systems and processes to safely prescribe and record medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The teams had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- The provider did not have assurance that clinicians who prescribed medication and worked remotely had suitable secure storage for prescription stationery.
- Clinicians were not always indicating that they had checked patients' identification, although the majority were following the policy to check patients' identification prior to consultations.

Good



### Are services effective?

We rated effective as good because:

Good





# Summary of this inspection

- Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of treatment and care for the patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives. This included sending NHS patients monitors so they could check their own heart rate and blood pressure during their consultations. The provider also delivered training packages around practical support in the community to adolescents transitioning into adult services.
- Staff used recognised rating scales to assess and record severity and outcomes. Outcomes, such as correct diagnoses and success with medication, for patients were positive, consistent and regularly exceeded expectations. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

## Are services caring?

### We rated caring as outstanding because:

- Feedback from patients, those who were close to them and stakeholders was continually and highly positive about the way staff treated people. Patients thought that staff went the extra

Outstanding



# Summary of this inspection

mile and their care and support exceeded their expectations. There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted patients' dignity. Relationships between patients, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders.

- Staff recognised and respected the totality of patients' needs. They always took patients' personal, cultural, social and religious needs into account, and found innovative ways to meet them. For example, the provider offered alternative ways to communicate during their consultation if they were too anxious to conduct a video conference, such as via email, text or on the phone. Patients' emotional and social needs were seen as being as important as their physical needs.
- Patients and those close to them were active partners in their care. Staff were fully committed to working in partnership with patients and made this a reality for each patient. Staff always empowered people who use the service to have a voice and to realise their potential. They showed determination and creativity to overcome obstacles to delivering care. Patients' individual preferences and needs were always reflected in how care was delivered.
- Staff recognised that patients needed to have access to, and links with support networks in the community and they supported patients to do this. They ensured that patients' communication needs were understood, sought best practice and learnt from it.
- Patients were always treated with dignity by all those involved in their care, treatment and support. Consideration of patients' privacy and dignity was consistently embedded in everything that staff did, including awareness of any specific needs as these were recorded and communicated.
- Staff found innovative ways to enable patients to manage their own health and care when they could and to maintain independence as much as possible. For example, supporting patients to self-regulate and by creating community support networks. Patients felt really cared for and that they mattered. Patients valued their relationships with the staff team and felt that they often went 'the extra mile' for them when providing care and support.

## Are services responsive?

We rated responsive as good because:

Good



# Summary of this inspection

- The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. Staff followed up patients who missed appointments.
- The service met the needs of all patients including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

## Are services well-led?

### We rated well led as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

However:

- The provider did not have a system in place to assure itself that all staff who prescribed medication and worked remotely stored prescription stationary in a locked cupboard when not in use.

Good



# Detailed findings from this inspection

## Mental Capacity Act and Deprivation of Liberty Safeguards






- Staff assumed patients had capacity to consent to their treatment unless there was a reason to assess for mental capacity. This was in line with the Mental Capacity Act. Consultants assessed and referenced a patient's capacity in their initial assessment. This was checked during nursing reviews and staff were able to describe the principles of assessing capacity. We reviewed 10 records of care and found that all had documented the patient had agreed to the terms and conditions of the consultation and had consented to treatment. A tick box was on the front page of all patient records to indicate if a patient was happy for the provider to contact their GP. A consent form was then sent to the patient once they had checked this tick box. Decision specific capacity was assessed and recorded in clinic letters. All patients we spoke to confirmed that they were asked to fill out a consent form before they started their treatment.
- The provider had a policy on the Mental Capacity Act that staff could refer to. The policy included a flow chart to enable staff to apply the act.
- When staff saw children and young people, they followed a protocol of initially seeing the parents first, then the child, then a joint consultation. Staff referred to the Gillick competencies if they were under 18, so if a young person was Gillick competent, the provider would seek permission from the young person before contacting their parents. All staff had received training in Fraser guidelines.

## Overview of ratings

Our ratings for this location are:

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

# Community-based mental health services for adults of working age

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

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

Good 

### Safe and clean environment

- Psychiatry services were provided remotely over the internet by psychiatrists and nurses working from their own premises. All staff signed an agreement to ensure their own premises were confidential and appropriate for private consultation. The appointments took place by video conference using the provider’s encrypted bespoke video conferencing system. Consultations could also take place over email and over the phone. The provider advised patients to be in a private space for their consultation and to wear headphones to protect their confidentiality.
- The provider did not have its own premises.

### Safe staffing

- The provider had sufficient staff available to meet the demand for appointments. There were 38 consultant psychiatrists, six nurse prescribers, 15 administrative staff, a chief operating officer, a business development partner, a safeguarding lead, a technology officer and a medical lead who was also the registered manager. Since our last inspection, the team also included attention deficit hyperactivity disorder (ADHD) coaches and occupational therapists. There were seven psychiatrists that specialised in child and adolescent psychiatry. The provider had appointed six nurse

practitioners since our last inspection who provided follow up support for patients with the administration of prescriptions. Consultant psychiatrists provided the front line support for all patients.

- The provider asked psychiatrists to remove their availability from the appointments system if they were sick or on leave. On the rare occasion that doctors were unable to attend their appointments this process was handled by the administrative team. If there were urgent issues that needed to be dealt with; for example, prescriptions or urgent questions, the administrative team referred the issue to the relevant service lead. If there was a need for the patient to be reviewed earlier than was possible by the original consultant, another consultant with earlier availability was allocated. If there was no urgency, then an alternative appointment with the original consultant was arranged. Cancellation due to provider issues resulted in no charge to the patient.
- There were no staff vacancies for the service and the provider did not employ agency staff.
- Mandatory training was provided to staff through the NHS, apart from safeguarding training which was provided by the safeguarding lead. It was the individual staff member’s responsibility to source their own training other than what had been provided to them. If staff did not keep up to date with mandatory training, the provider removed them from the online calendar until they had completed the required training. The majority of staff (97%) had completed mandatory training.
- The provider asked staff to provide proof they had completed mandatory training. All training certificates were uploaded onto the provider’s online HR system. The systems showed the date of completion, the expiry date and the attached certificate was uploaded.

# Community-based mental health services for adults of working age

- The provider uploaded all disclosure and barring service (DBS) forms onto their online HR system and regional admin teams checked these every year. We checked a sample of personnel files and found that all had up to date DBS records uploaded
- The provider had a contract with an external agency that checked all doctors had completed revalidation. The provider was notified if any revalidation was about to expire. Revalidation checks were completed on the provider's online HR system.

## Assessing and managing risk to patients and staff

- We reviewed ten care records during our inspection. We found that all ten records had a section for assessing risk and this was completed for those patients with an identified specific risk. Staff completed a risk assessment during the patient's initial assessment and updated it if required after a consultation.
- Psychiatrists did not use a risk assessment tool for assessing risk. However, following a consultation, the psychiatrist compiled a detailed letter which contained separate headings, one of which was 'risk assessment'. The letters detailed short term and long terms risks for the patient.
- Psychiatrists were not consistently creating and recording crisis plans for patients. However, they did make recommendations in their letter about crisis plans and additional support and what to do out of hours.
- Patients could decline to have the psychiatrist send a letter to their GP following their consultation. However, all patients were required to give their GP details in case staff needed to pass on important information. If a patient was prescribed medicines or there were serious concerns about risk, the psychiatrist would still contact the GP in the interests of safety, even if they had to do so without the patient's consent. The registered manager gave examples of when psychiatrists had taken prompt action to respond to a major risk to a patient's health. This included calling emergency services or making urgent contact with the patients' GP. Staff informed patients that their care would be safer if their GP were involved. The provider did not prescribe medication to patients who declined to share their information with their GP, or who were not registered with a GP.
- The provider routinely contacted patients once referred so they did not have to bear the cost of the call. Doctors relied on information gathered prior to the consultation

to check the patient's address and where they might be calling from. This information was given to the provider by the patient's GP in the form of a summary care record.

- If, during a consultation, a patient became physically or mentally unwell, staff contacted either the safeguarding lead for the organisation, the local single point of access team or emergency services. Staff followed a flowchart which outlined the process of what to do in this situation.

## Safeguarding

- Since our last inspection, the provider had employed a safeguarding lead. The safeguarding lead had a lead role within the organisation for patient safety issues, incident reporting, implementing safeguarding policies and procedures, training, safeguarding supervision and offering staff advice and support. The safeguarding lead enabled staff to access on-line training, monitored staff to ensure they were up to date with safeguarding training and provided face-to-face training during the provider's annual general meeting. Since our last inspection, the provider had published updated safeguarding policies for children and adults which were available for staff and patients on the provider's website. There was a flowchart at the beginning of the policy for staff to follow if there was an urgent safeguarding concern.
- Staff were able to describe examples of raising safeguarding concerns. They explained how they made decisions about raising alerts.
- We saw evidence in patients' care records that where a safeguarding issue had been identified, the safeguarding lead provided immediate and continual input as the issue progressed and until it had been resolved.
- All psychiatrists had completed levels one and two training in safeguarding for adults and all had completed level three for safeguarding children.
- Staff took extra precautions when offering appointments for children and young people. They required the patient's GP to make contact with them first so they could ask about any known risks or relevant history. All children and young people were initially seen but if a child was highly suicidal, for example, the psychiatrist would refer them back to urgent or emergency services. The provider had seven psychiatrists specifically qualified to work with children

# Community-based mental health services for adults of working age

and young people. Services for children included research, an online assessment, diagnosis, a written report, medication titration and a mandatory follow up appointment four to six weeks later.

## Staff access to essential information

- Records were stored online to reduce the risk of a breach in patient confidentiality. Some records had to be downloaded onto staff's personal computers. However, staff signed an agreement in their contracts to delete information as soon as it was no longer being used. The provider audited this by going through the consultants' downloads folder.
- All test results, prescriptions and letters were saved appropriately. Documents that needed editing were downloaded, edited then deleted.
- Since our last inspection, the provider had put in place protocols and reminders for psychiatrists to check the identification of the patient at the beginning of the consultation.
- The provider had a patient identification policy. The provider asked patients to identify themselves using recognised documents when they attended an online consultation. Patients displayed their photographic identification document to the camera and the consultant recorded that they had seen it. As this was a requirement notice from our last inspection, the provider had since completed three audits on the recording of patient identification which showed improvements were being steadily made. However, some psychiatrists did not always identify on the notes that they had checked the identification of the patient although the majority were following the policy for checking a patient's identification before a consultation. The provider showed that they had been working consistently towards increasing compliance and had put systems in place, such as pop up reminders, to remind doctors to do this. There was a tick box on the front page of a patient's notes for staff to note if they had checked the person's identification. Two out of the ten records we reviewed showed that doctors had not ticked to say they had seen patient identification. When nurses prescribed medication for patients, they checked that identification had been seen before completing the prescription. The provider audited all consultations, rather than solely the consultations requiring prescribing, so doctors got into the habit of checking for identification at every session. The provider routinely

asked for a live presentation of documentation rather than scanning in documents to reduce the risk of storing patient information unnecessarily. We spoke directly with eight patients who were currently using the service and they all confirmed they displayed their photographic identification at the beginning of their consultation.

- Since our last inspection, the provider had put processes in place to effectively identify and mitigate the risks of patients holding multiple separate accounts with them. Regional administrative staff conducted searches of duplicate names and had a system in place that flagged if a known patient booked an appointment on the website.
- All staff had a two-step authentication process when accessing patient records to reduce the risk of unwarranted people accessing patient information.
- The provider had plans in place to move to electronic prescribing which required access to the NHS spine. (The NHS spine joins together healthcare IT systems.) The provider anticipated that the more NHS contracts they received, the more access they would have to be able to move over to this electronic system.

## Medicines management

- The provider had an up to date medicines management policy.
- Patients filled in a screening form before their initial appointment. Following this, staff ensured baseline physical health tests, such as blood tests and monitoring were completed before they initiated prescriptions. If a GP surgery did not complete this, a private provider was identified locally before medicines were prescribed. Prescriptions were for a one-month supply of medicines and requests for a larger supply were reviewed on a case-by-case basis. The reason was recorded in the patient notes.
- Once medicines had been titrated a referral was made to the patient's GP to continue the prescribing. Nurse prescribers managed the titration of medicines. There was a non-medical prescribing lead who supported and provided peer review. Nurse prescribers were also supported by a lead consultant.
- Staff sent handwritten prescriptions to the patient in the post, but they could also send them to a pharmacy at the patient's request.
- Consultants were responsible for ordering their own prescription pads. The HR manager also ordered

# Community-based mental health services for adults of working age

prescription stationery for the nurses. The serial numbers were tracked. However, the provider did not obtain assurance that prescription pads were being stored securely.

- All prescriptions were sent out via the royal mail's tracked delivery service. Most tracking numbers were then recorded on the provider's electronic database and the registered manager kept all postal receipts. We found one instance when a psychiatrist had not recorded the tracking number on the patient's file.
- The provider only issued prescriptions when patients agreed to the provider sharing information with the patient's GP. This meant the patient's GP was aware of all the medicines the patient was taking and could be aware of possible side effects or interactions. Where possible, psychiatrists asked patients to agree to ask their GP to prescribe for them. This was cheaper for the patient and if patients declined to have their GP informed of the consultation, then the psychiatrists made a judgement about whether or not their GP needed to be aware in order to safeguard them. In some cases, in order to ensure patients settled on the correct dosage of medicines, psychiatrists monitored blood results and blood pressure readings that the patients took themselves. Most patients being treated for attention deficit hyperactivity disorder were monitored by the service until they had titrated and then the GP took over treatment. Follow up services were run by nurses who continued support for a patient until they had become stable enough for their GP to take over prescribing. Medicines were not prescribed if a patient was currently receiving medicines by an NHS community mental health team.
- Patient consent was recorded to access their summary care records and to share information with their GP. If the process of acquiring these from the GP was taking too long, occasionally treatment was initiated before the records were seen, although this did not include prescribing. Letters were sent out to a patient's GP following the consultations. Patients under 18 required parental/guardian consent.
- Staff completed quarterly peer reviews of staff prescribing medication. One record was reviewed per clinician. Any prescribing of medicines that was outside of recommended guidance was reviewed. Medicines central alerting system alerts were reviewed and cascaded to staff if relevant.

## Track record on safety

- The provider had experienced one serious incident in the past 12 months of a patient suicide. This incident was reviewed, areas of good practise identified such as the risk assessment and history of recent events and ongoing liaison with external providers. Following this incident, monthly liaison meetings, attended by senior clinical staff, were arranged with the staff and all non-clinical members of the commissioning organisation came together to support them in their work following the incident.

## Reporting incidents and learning from when things go wrong

- Staff were familiar with what a notifiable incident was and the process on how to report an incident via the incidents inbox. The provider had an incident reporting policy. The policy addressed how incidents were logged, investigated and lessons learned. Incidents were reviewed every week during the weekly executive meeting and was a standing agenda item. Follow up plans relating to the incident were developed during this meeting. Staff gave examples of shared learning within the team relating to specific incidents.
- Staff received a de-brief following incidents. Staff were made familiar with the incident reporting policy during induction. There was also a mandatory training video for staff to watch. When an incident had been investigated learning was then considered and disseminated to staff. For example, the provider had developed a zero tolerance policy for staff to follow after an incident of patient aggression. Staff described that the provider had a culture where there was no blame associated with incidents. Staff felt able to report incidents.
- The provider had a duty of candour policy and we saw evidence of the provider considering and discharging its duty of candour during our review of incidents and complaints. Staff were open and transparent and explained to patients if something went wrong. They had a low threshold for offering a refund to patients if they were unhappy with the service provided or if staff made a mistake.
- The safeguarding lead also collected and collated incident reports and produced regular updates for staff on good practise.



# Community-based mental health services for adults of working age

**Are community-based mental health services for adults of working age effective?**  
(for example, treatment is effective)

Good 

## Assessment of needs and planning of care

- We reviewed 10 records of patient care. Care records were recorded in the form of an assessment letter. All care records we reviewed contained completed self-reports which meant the patient's view and preferences were always captured. Physical health observations were recorded in all records we reviewed. Consent to treatment was completed in all records as were risk assessments and safeguarding information if required.
- Psychiatrists completed a comprehensive assessment during the first appointment. Our review of patient records showed assessments were up to date, personalised, holistic and showed an emphasis on recovery-oriented care. The provider did not have a specific tool for making clinical decisions but did use a generic template that all staff completed, which followed guidance from the royal college of psychiatrists training. All psychiatrists were trained to complete a standard assessment that included previous psychiatric history, physical health history, medication history, personal history, school, employment and relationships history, substance misuse, family history and mental state examination. Before working with a new patient, the provider wrote to their GP to request their summary care records. The provider could occasionally see patients before this information arrived but they did not prescribe until they had all of the patient's physical and mental health information.

## Best practice in treatment and care

- Psychiatrists followed guidance issued by the National Institute for Health and Care Excellence (NICE) when prescribing medication and provided a rationale when they deviated from guidelines. Staff demonstrated a good understanding of best practise in monitoring procedures, safety mechanisms and prescribing. The provider was registered for NICE news which kept them

up to date with important developments at NICE. These were then reported on in the clinical operations meeting and disseminated via the provider's newsletter or via a secure messaging group to staff. The group then decided if the updated information led to a decision to carry out an audit or review and update policies.

- The provider had a policy on prescribing medication which followed NICE guidance. Staff followed a protocol with ADHD prescribing for suggested consideration of how to proceed with medication.
- Staff followed NICE guidance about prescribing drugs with low risk dependency. They also followed a standard operating procedure of how to prescribe.
- The provider did not offer psychological therapies. Staff signposted patients to national bodies where they could search for suitably qualified professionals for private psychological treatment.
- Staff monitored patients' physical health monitoring by asking them to complete self-reports. For example, a cardiac health questionnaire. Patients with ADHD completed a specific ADHD self-report which asked questions based on NICE recommendations for screening for ADHD. Patients with ADHD were given heart monitors they could use on line and patients could take photos of their weight and blood pressure, for example, to show their psychiatrist during the consultation.
- Doctors always gave patients the full range of options for treatment. In the majority of cases physical examination or further investigations were not required in their patient group. When issues were identified which required either a physical examination or investigations such as electrocardiogram or blood tests, a request was made to the patient's GP for these to be conducted.
- We spoke to staff about the challenge of assessing patients without physically seeing them. Whilst adults could book an appointment directly, children and young people needed a referral from their GP to access the service. This was to ensure psychiatrists had access to adequate information about the child before their appointment. The administration team also collected basic information such as the child's school and social worker if they had them so the service could liaise with them as required. If a child had a previous psychiatric

# Community-based mental health services for adults of working age

history the provider obtained previous reports and letters. Psychiatrists consulting patients for ADHD received information about patients in advance of their assessment.

- Patients said that staff gave them advice on healthier lives, such as changing lifestyle choices to reduce alcohol intake and increase healthy eating and exercise.
- The provider used approaches to rating the severity of a patient's condition, for example, they used the 'Adult ADHD Self-Report Scale' to help them diagnose ADHD in adults. The attention deficit hyperactivity disorder group was working on essential standards for assessment, including how long the consultation should take.
- The provider completed audits to ensure the service continued to improve. The provider held quality improvement meetings every three months. The provider completed audits in pre-employment checks, case note reviews (in which a panel peer reviewed care records every three months to check doctors were prescribing appropriately and recording adequate information) and identification audits. These audits resulted in recommendations and an action plan that were discussed in the management team and informed all staff. In the ADHD service an audit had been conducted and re-audited in the last 12 months reviewing assessments of physical health issues such as cardiac history. The results led to a change in practice with additional information gathered prior to the assessment to ensure that sufficient information was available at the time of the initial assessment to make appropriate recommendations to the patient. The provider also audited prescribing adherence to NICE guidance.
- The provider audited staff appraisals, to check the organisation was included in the scope of the appraisal. The provider also audited how long it took for doctors to send out their letters to the GP. This was an area of development for the provider at the time of our inspection.

## Skilled staff to deliver care

- The service was mainly run by psychiatrists but also employed nurse prescribers, ADHD leads and occupational therapists.

- There were 12 specialist ADHD doctors within the team and five specialist adult and children ADHD prescribers. All non-medical prescribers were required to have previously worked in an adult ADHD service and also have adult mental health nursing experience.
- Training in being an approved clinician for section 12 of the Mental Health Act was completed by 92% of eligible staff for adults and 86% for children.
- During induction, the provider checked that psychiatrists were on the GMC register and had a licence to practise. All original documents such as qualifications and DBS records were uploaded onto the provider's online HR system. Licences to practise were checked annually.
- The provider provided indemnity insurance for all doctors which insured doctors living outside of the UK and patients living in the UK. Nurses were required to provide their own indemnity insurance.
- Psychiatrists that joined the service completed an introduction to the software with an administrator. Staff were required to sign to say they had read and understood the provider's policies. New staff were asked to read the consultation manual. Since our last inspection, the provider had formalised their induction procedures. The provider had an induction checklist that included checking the staff member had signed the consulting agreement, been sent the consulting manual, been added to indemnity insurance, created a website profile, gone through their training requirements, had an induction with the admin team, an introduction to the newsletter and had been added to the secure messaging group. The provider now had a system in place that showed which staff had read the consultation manual, updated polices and the provider's newsletter.
- Medical staff received peer supervision every three months. Supervision records were stored on the provider's online HR system. Staff also received additional peer supervision, were part of a secure messaging group and attended annual general meetings. Nurses received three monthly supervisions with a psychiatrist. In addition, they had monthly professional peer supervision via professional peer groups, which covered matters such as service updates, prescribing standards, safeguarding, the titration

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service, capacity and NHS contracts. Each nurse shared one prescribing case in every meeting followed by discussion to maintain standard practice across the team.

- Doctors with a special interest in ADHD or doctors who worked specifically with children attended additional peer supervision groups.
- The prescribing competency framework was discussed at supervisions and using an ADHD prescribing example related it to one of the 10 standards within the framework.
- Appraisals were provided by an external medical professional company or by staff's NHS employer. Appraisals included checking there was a discussion around the scope of including the provider in the appraisal. All staff had received appraisals that included consideration of specialist training needs. The registered manager audited that all appraisals included the provider in their discussion.
- The provider dealt with poor performance promptly and effectively. We saw examples of doctors who had not completed their mandatory training being taken off the availability calendar until they had accomplished this. The registered manager audited recorded consultations and we saw one example of a disciplinary meeting with a doctor who was not performing adequately against the provider's values.

## Multi-disciplinary and inter-agency team work

- The provider held weekly management team meetings and monthly meetings attended by the medical lead, chief operating officer, business development lead and designated members. Staff did not regularly attend team meetings and this was not a requirement. The weekly executive meetings discussed the provider's risk register and progress against actions. The meeting also reviewed key performance indicators, complaints and incidents, finances and staff wellbeing. There were also regular clinical meetings and weekly administration team meetings.
- Staff joined a secure online messaging service chat group to share information and also read a monthly newsletter for service updates.
- Psychiatrists working in the service linked with the patients' GP. Although patients could decline to have information shared with their GP, the provider only allowed this when it was safe to do so. In all other cases the psychiatrist wrote to the patient's GP after each

consultation. The provider advised patients of the risks of not informing their GP of their appointments and outcomes. Staff talked this through with patients during their appointments and also documented this in their letters. If there were risk issues, the provider contacted their safeguarding lead who would liaise with the patient and their GP. Staff documented patients' consent to contact their GP on the front page of their patient records.

- Psychiatrists made contact with other agencies to aid their work with patients and to pass on important information. In particular, when consulting with children, the psychiatrists also worked with schools, social workers and other professional bodies. Staff also had strong links with ADHD networks. They worked closely with clinical commissioning groups to manage sub contracts with
- some NHS trusts for ADHD. Although a privately funded service, the provider was increasing its work with the NHS. The first NHS contract was signed off 18 months ago and work has since increased with trusts to manage their ADHD waiting lists. The provider worked with NHS compliance managers to ensure this was done in line with the NHS constitution.
- The provider held close working relationships with their commissioners and had mandatory reporting obligations to them. The provider also met regularly with national ADHD leads to ensure they were following national and local policies. Staff had scheduled meetings with care co-ordinators to ensure continuity of practice and support and exchanged letters with local crisis teams if required. Staff attended local intelligence network meetings for prescribing controlled drugs in line with national guidance.
- We received positive feedback from commissioners of the service. Commissioners said that they felt the service was safe, accessible and responsive. Commissioners said that the provider complied to clinical standards, information governance, security, cost and flexibility. Commissioners working with the provider to develop ADHD services recommended them as good working partners and said they would recommend the provider to other commissioners.
- Commissioners said that the provider were patient focused which meant they engaged with patients to seek a solution and were active in finding ways to communicate to meet the patient's needs.

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- Local clinicians said that doctors contracted to work for the provider actively engaged with them to get feedback about developing their service.
- NHS providers who had contracts with the provider confirmed they had reduced their wait list for ADHD services and they had seen a positive impact on their teams with the number of patients they were since able to see. NHS providers said they produced clear and comprehensive invoices that detailed the services delivered.
- External providers said the provider invited them to review their services and that they listened and learnt from feedback.

## Adherence to the MHA and the MHA Code of Practice

- Psychiatrists were trained in the Mental Health Act as part of their core training although the provider did not currently offer a service to patients who were detained under the Mental Health Act.

## Good practice in applying the MCA

- Staff assumed patients had capacity to consent to their treatment unless there was a reason to assess for mental capacity. This was in line with the Mental Capacity Act. Consultants assessed and referenced a patient's capacity in their initial assessment and in nursing reviews. Staff could describe the principles of assessing capacity. We reviewed 10 records of care and found that all had documented the patient had agreed to the terms and conditions of the consultation and had consented to treatment. A tick box was on the front page of all patient records to indicate if a patient was happy for the provider to contact their GP. A consent form was then sent to the patient once they had checked this tick box. Decision specific capacity was assessed and recorded in clinic letters. All patients we spoke to confirmed that they were asked to fill out a consent form before they started their treatment.
- The provider had a policy on the Mental Capacity Act that staff could refer to. The policy included a flow chart to enable staff to apply the act
- When staff saw children and young people, they followed a protocol of initially seeing the parents first, then the child, then a joint consultation. Staff referred to the Gillick competencies if they were under 18, so if a

young person was Gillick competent, the provider would seek permission from the young person before contacting their parents. All staff had received training in Fraser guidelines.

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

Outstanding 

### Kindness, privacy, dignity, respect, compassion and support

- We received positive feedback from patients and their families about the support they received from the provider. This feedback was reported on our feedback system, the provider's website and some provider review websites. Patients consistently said that the support they received was over and above what any other provider had offered them in the past.
- We saw that staff were highly motivated to work with patients to assess, explain and give diagnoses that some had been waiting years to receive. Patients said this had been life changing for them.
- We received positive feedback from patients that showed they were very satisfied with the service they received. Patients reported staff were kind and respectful. Patients said psychiatrists got to know them before making treatment recommendations. Patients' feedback showed the service helped people to make positive changes to their lives.
- Patients could view each consultant's profile in order to choose one that matched their requirements, such as doctors who worked specifically with patients with attention deficit hyperactivity disorder (ADHD) but also had experience in substance misuse and trauma.
- Patients said they could raise concerns without any fear of consequence.
- The provider had a privacy policy and an information governance policy. The privacy policy was available on the website for patients to read before they used the service. The privacy policy covered confidentiality and the reasons for recording sessions. The provider took steps to ensure the security of its data including the use of encryption and firewalls. This was to ensure they preserved patients' confidentiality. The provider commissioned external testing of its server to assure

# Community-based mental health services for adults of working age

itself of the security of patients' information. In order to ensure records were safe, only clinicians who were involved in a patient's care could access the patient's care records. Psychiatrists could log into the server to access clinical information and to complete patient records.

- Patients were required to agree to terms and conditions before commencing an appointment. This meant that the provider could ensure patients were fully aware of how their records were stored and managed.

## Involvement in care

- Patients told us they felt involved in their care including decisions made about treatment and prescribing. Patients said that they had care plans and knew where they were going with their treatment. Patients said that the psychiatrists had explained their medication to them and any side effects. Patients' families could be involved in their care if the patient requested it. The provider did not consult with children without the involvement of the parent or carer. Carers told us they felt supported and involved.
- Staff automatically shared referral letters and test results with patients. On patients' care records, there was a tick box options to 'share with patient' or 'doctor only'.
- Staff had a conversation with their patient if they wanted any sections of their medical records removed before sharing with other health professionals. At the end of each letter, there was a statement that requested the patient to agree if the content of the letter was accurate. This meant patients could correct any errors in clinic letters before they were sent out.
- Patients could access audio recording of their consultations. Communication with the patients was via the online portal on the website. An alert was sent to the relevant clinician when there was a message.
- The business development lead gave several examples of how patients had been consulted about improvements to the way the service developed using their direct feedback to make changes. For example, the way patients were charged for titration services.
- There were a variety of ways for patients to feed back about the service including making contact directly or leaving feedback with an independent third party. The management team reviewed feedback in weekly meetings. Patients could feedback about the service via telephone, email, third party independent websites and

via the provider's software system where at the end of each consultation, a window automatically appeared asking whether the patient would like to leave any feedback. They could leave a star rating out of five as well as a comment. The provider displayed these ratings in the booking system so that patients could see them at the time they chose a consultant and they shared feedback with staff. Since February 2019, the provider received 500 ratings from patients with 99% of those rating them five out of five stars.

- The provider encouraged patients to engage with other patients with similar conditions by directing them to vetted and monitored groups on social media sites, set up by the provider themselves or by others. As well as offering advice and encouragement, they also engaged in debate and initiated discussions about service improvement and how the opportunities of online engagement could best be utilised. This also allowed an unofficial route to contact the provider to raise issues or ask questions, without making formal representations. The provider's emphasis was on peer support and the use of informed engagement to encourage and aid recovery.

**Are community-based mental health services for adults of working age responsive to people's needs? (for example, to feedback?)**

Good 

## Access and discharge

- The provider did not have a waiting list for its services. Administrators offered patients an appointment when they phoned the service or they could book an appointment themselves through the website and did not need referral. Patients were normally offered an appointment within 96 hours. Patients could choose a psychiatrist on the website, view the next upcoming appointment and book onto that. All patients using the service at the time of our inspection said that they were offered an appointment within four days.
- The provider did not offer an urgent service but in many cases could see patients the following day, depending on their difficulties. If patients selected a particular psychiatrist, they sometimes had to wait longer.

# Community-based mental health services for adults of working age

- The provider had regional administration teams to make bookings and appointments. Although the administration team did not provide risk screening they were all experienced in working within the NHS and a partner was on-call to offer advice and support when required. The website had a button patients could click on to get advice and contact details of national services in an emergency.
- The provider aimed to see patients and try to help them without proactively screening people out. The registered manager told us almost all their patients had tried to access help from other services but had encountered barriers. Rather than exclude patients, the registered manager said they would initially see all patients and then decide whether or not to offer treatment.
- The provider took a proactive approach to re-engaging with people who failed to attend their appointments. They retained the right to keep the fee but would offer another appointment depending on the circumstances. Patients told us appointment times were flexible and available at times to suit them. There were no complaints about appointments being cancelled or running late.
- If there was an interruption or termination of the connection during a consultation, staff followed guidance from the provider's manual which advised them to contact the patient by phone or email. Staff then asked the patient how they wished to continue. Staff would also email or phone a patient if they did not attend the consultation.

## The facilities promote recovery, comfort, dignity and confidentiality

- Staff followed clear guidance on the provider manual about ensuring their working space was confidential. Staff encouraged patients to check their own environments and use headphones for confidentiality, which the patient could choose to adhere to.

## Patients' engagement with the wider community

- The provider did not provide support around access to education and work opportunities, unless this was one of their main psychiatric difficulties. The provider signposted patients to additional services that may be required to support their recovery.

- Staff supported patients to maintain contact and maintain relationships with their families by allowing them to become involved in the patient's care should they agree to this. All doctors ensured patients under the age of 18 were seen with their parent at the initial appointment.

## Meeting the needs of all people who use the service

- The provider deliberately attempted to remove barriers for people who might have difficulties accessing services, for example, those with disabilities or anxiety disorders that prevented them accessing face to face treatment. Psychiatrists had worked with hearing impaired patients using text, for example. Patients who did not wish to use video conferencing or speak on the phone could have consultations via e-mail.
- Staff working for the provider held a wide range of languages so patients could normally communicate in their first language. The teleconferencing programme had a text chat facility so patients and doctors could communicate via text if they preferred. Patients could also participate via email.
- The provider accommodated patients who needed appointments to fit around their work and other commitments. Accessing the service from home or a venue of their choice was convenient for people. They could access the service providing they had an internet connection and a device. Patients had fed back that they were unable to access the service using mobile phones so the provider created mobile applications to enable patients to do so.
- The provider did not have any patients who required accessible information.
- Staff recorded in patients notes as part of the template record that they had sought informed consent from their patients.

## Listening to and learning from concerns and complaints

- There were systems in place to investigate and learn from complaints. The provider had a complaints policy which staff followed. All complaints were sent to a dedicated email inbox and then triaged for investigation based on the type of complaint. Complaints were discussed at the weekly management meeting and was a standing agenda item for discussion. Learning from complaints was shared with all staff by email to inform

# Community-based mental health services for adults of working age

them of the learning and the provider monitored to ensure staff members had read the information. Learning from complaints was also shared in the monthly newsletter which went to all staff.

- Information about how to complain was on the provider's website in their terms and conditions. The provider's complaints policy was also on their website and explained how to make a complaint or offer feedback. The policy also described how to take up a complaint with the General Medical Council or the European Online Dispute Resolution platform.
- Patients could complain via email or telephone.
- Patients we spoke to at the time of our inspection knew how to complain; either via the website, to external agencies or to the provider directly.
- There had been 24 complaints made against the provider in the past 12 months. Fifteen of these were upheld or partially upheld with the provider sending out a full apology and refunds in some cases. Complaint themes were around IT issues.

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

Good 

### Leadership

- The provider had a stable leadership team. The management board consisted of a medical lead, chief operations partner, business development partner, chief technical partner and eight designated members. Staff felt the leadership team were approachable and accessible when required.

### Vision and strategy

- The provider had established visions and values in February 2019. These were to be innovative, accessible, compassionate and provide high quality care.
- The provider's visions and values were available on their website. The provider's vision and values were developed in collaboration with staff. All staff were asked to complete an anonymous survey on what they felt the provider's values should be. The most prevalently mentioned values were identified and adapted into the values of the organisation. The new

values were launched at the provider's annual general meeting to all staff. The values are reinforced to staff in the consulting manual which all new starters were provided with.

### Culture

- Staff were proud to work for the organisation. Staff we spoke to told us morale was good. There was an open and transparent culture among all staff in the organisation and a focus and emphasis on patient care.
- The provider used a range of mechanisms to promote an engaged culture. This included social media groups, a secure messaging group and monthly newsletters.
- Staff told us they felt able to raise concerns and were aware of the provider's whistleblowing policy. The provider also had a freedom to speak up guardian.
- The provider had a duty of candour policy. All staff had to sign up to the policy. The policy set out expectations for all staff. Staff said the provider had a culture of no blame associated with incidents. Staff felt able to report incidents. Incidents were assessed as to whether they met the threshold for duty of candour. There was a process in place about contacting the patient, either by phone or in writing.

### Governance

- The provider had governance systems in place to monitor and improve the service delivered. The provider completed audits, monitored and investigated incidents and complaints. The provider held weekly executive meetings, regular clinical meetings and weekly admin team meetings. The weekly executive meeting had governance issues as a standing agenda item. Minutes from the meetings we reviewed confirmed governance was discussed as a priority. Since the last inspection the provider had established a new HR system, supervision policy, recruitment and termination policy, monitoring of mandatory training and strengthened governance processes. There were systems in place to report and learn from incidents and complaints. Learning from incidents was also shared in the monthly newsletter which went to all staff.
- The provider had strong governance arrangements in place around information technology and had recently appointed a chief technology officer.

# Community-based mental health services for adults of working age

- The provider had implemented new systems to ensure all staff passed a disclosure and barring service check prior to taking up employment. The provider had policies around recruitment and kept detailed HR files for all staff.
- The provider ensured staff received supervision. Staff received supervision on a quarterly basis. Staff also received monthly peer supervision which included topics such as prescribing standards, safeguarding and capacity.
- The provider recorded all consultations between psychiatrists and patients. This was from a quality perspective and also used in the event a complaint was made about a consultation. All patients consented to the consultations being recorded and it was stated in the provider's terms and conditions that interactions would be recorded. These recordings were available to patients at their request.
- The provider had safeguarding lead. Safeguarding policies had been updated and staff training was regularly monitored for compliance.
- The provider gave advice on how to set up a safe working environment in the provider's manual.
- The provider worked to a terms of reference document. This document detailed the structure for the board of designated members to hold themselves to account about risk and performance. The document clarified the risks to the service that could compromise strategic objectives and assisted in determining efficient use of resources to improve quality, safety and performance. The terms of reference set out a reporting structure and required monthly reports on areas such as risk mitigation and performance issues to be submitted for consideration.
- The provider had a risk register which was discussed in weekly executive meetings. Risks were clearly identified and mitigations were put in place to address each risk. Risks were rated. Each risk was assigned to a senior responsible officer who was accountable for progress against each risk and mitigation. IT issues were on the risk register in 'amber' status. There was an action plan around using telephone or email contact when connectivity was problematic during a consultation. Other risks in amber status were the audit about ensuring patients showed their photographic identification during their first consultation. This was at 75% compliant and reminders had been put in place for all doctors to request this. Financial insolvency was also a risk in amber status and an action plan had been put in place to appoint a finance director to resolve this.

## Management of risk, issues and performance

- The provider had a policy on what constituted supervision and how often staff should be supervised. All staff had a dedicated supervisor and they met every three months. There was a structure for the meeting and a standardised form to complete. Staff were also involved in a peer review process. Every three months, four doctors and one nurse formed a panel and reviewed random cases for each doctor. The panel assessed good psychiatric practice standards against the provider's values and recorded any areas for improvement.
- During the peer review, the panel checked staff performance, for example if the doctor did not send out a patient's letter with the standard seven days of a patient being seen.
- All staff aimed to meet once a year in person at the provider's annual general meeting.
- Staff received an annual appraisal with an external company who provided appraisals to small companies. Although the appraisal was not specific to the provider, appraisals included the provider in the scope of the staff's work. The registered manager audited these appraisals to check that the provider had been included in the staff member's objectives.

## Information management

- The provider had a range of policies and procedures in place in relation to data protection. The provider's electronic systems had passed a penetration test and were also cyber essentials accredited. The provider was compliant with the data protection security toolkit. The provider was compliant with the general data protection regulation (GDPR) and had implemented an associated policy. Staff undertook training about GDPR. The electronic system had two factor authentication. The provider's IT security policy had been updated to require that all staff members hard drives were encrypted. The provider had appointed a chief technology officer. The IT policies were reviewed and updated every six months. There was also a working group who met to discuss the IT software. Staff from the senior executive team and other staff members were part of the group's membership.



# Community-based mental health services for adults of working age

## Engagement

- The provider actively engaged with staff in a variety of ways. The provider recognised there were some challenges with staff working remotely and put measures in place to address this. Staff we spoke to were positive about the provider and the way they were engaged with. There was a monthly newsletter called 'Brainwave' which was sent to all staff. The newsletter profiled two staff members each month so other staff could get to know each other and had a range of other topics including learning from incidents and complaints. The provider held a staff survey every six months to engage staff about service delivery. Following the staff survey the provider developed an action plan to address themes from the survey. There were staff forums available to provide additional support to staff. To aid with staff wellbeing the provider had introduced corporate yoga. This was available to staff via the provider's electronic system and a professional yoga teacher ran these sessions. The provider celebrated staff success through their HR electronic system. There was a 'give kudos' section where staff could post comments about other staff members when they had done something particularly well. There was also a secure messaging group for staff for social interaction and also a group for professional matters. The provider listened to feedback from staff. For example, the administration team had requested additional training on personality disorders as a number of patients who called the service had a personality disorder. A consultant psychiatrist delivered a training session for the administration team about personality disorder.
- The provider had a fit and proper persons policy. Psychiatrists on the management board completed an annual declaration about their continued fitness for the role.
- The leadership team were proud of the service. Staff morale was good and there were opportunities for

psychiatrists that specialised in children and young people or attention deficit hyperactivity disorder to work together to develop the service and to support each other. There was a good culture of staff discussing clinical questions by email and offering advice.

- The engagement lead for the provider interacted daily on social media sites with both their patients and patients of other mental health services. They invited those who were interested in support groups or seeking support to participate in their own development forums with the ideas that were generated. They particularly engaged with local groups in the areas in which they have NHS contracts.
- The engagement lead had set up new groups for patients to engage in the development of support services around particular needs. For example, training and coaching packages for adolescents with neurodevelopmental conditions transitioning to adult services. These were provided by suitably accredited behavioural management specialists, working under the provider's medical supervision, who joined in on their forums with the discussions. The intention was to provide a medically supervised mutual support service with patient volunteers participating both in the development and the ongoing provision.

## Learning, continuous improvement and innovation

- The provider had successfully achieved cyber essentials accreditation. Cyber essentials is a UK government information assurance scheme that encourages organisations to adopt good practice in information security.
- The provider worked collaboratively with clinical commissioning groups to acquire contracts that took over some NHS ADHD services. This meant that NHS wait times for these services were reducing and patients were not having to wait a long time for an appointment.

# Outstanding practice and areas for improvement

## Outstanding practice

Patients told us that the provider had changed their lives by offering a responsive and efficient consultation and diagnosis. We heard about examples where patients who had previously been too unwell to work had returned to work as a result of the provider's input and prescription of the right medication.

One of the founders of the organisation had attention deficit hyperactivity disorder (ADHD) and with this and the feedback from patient involvement groups, had managed to steer the ethos of the company to ensure their practises reflected the needs and wishes of people with ADHD.

The provider had started to take on NHS contracts to support people on a long waiting list to access an appointment. Patients we spoke with said they had been waiting for years to be seen and after finally being seen by the provider were able to move on with their lives.

Due to consultants working for the provider living in various parts of the world and working in different time zones, the provider was able to offer appointments to patients at any time of the day or night.

## Areas for improvement

### **Action the provider SHOULD take to improve** **Action the provider SHOULD take to improve**

- The provider should continue to audit compliance to confirming the identity of the patient before commencing each consultation. The provider should

assure itself of the identity of its patients for the purposes of safe care and treatment and ensure the procedures are understood by all staff, implemented consistently and regularly reviewed.

- The provider should put systems in place to have assurance that prescription paperwork is stored securely.