

The Child and Family Practice







Quality Report

60 Bloomsbury Street
London
WC1B 3QU
Tel: 020 7034 2690
Website: www.tcfp.org.uk

Date of inspection visit: 24 January 2018
Date of publication: 23/04/2018

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated this service as **good** because:

- The environment was clean and tidy. The service was accessible for patients with mobility needs. Staff were flexible when arranging appointments for patients, who could access the service on weekends and evenings.
- Staff were trained in adults and children's safeguarding and knew how to make an alert.
- The service had clear procedures for incident reporting and complaints. Staff addressed incidents and complaints in an appropriate manner and discussed learning at multi-disciplinary meetings.
- Staff met regularly to discuss complex cases, treatment and referrals. Patients had access to a wide range of skilled and experienced professionals. This included psychiatrists, psychotherapists, family therapists, paediatricians, occupational therapists and psychologists.
- The service conducted specialist multi-disciplinary assessments with input from a range of different professionals and offered psychological therapies in line with NICE guidance.
- Educational consultants supported staff, patients and families with communication between schools and other agencies. Specialist dietitians supported patients with eating disorders on nutrition and eating plans.
- Staff treated patients with respect and care.

However we found the following issues that the service needs to improve:

- Systems were not in place to ensure clinicians maintained accurate, up to date and comprehensive patient records. Senior managers did not have oversight of how staff assessed risk and made decisions regarding treatment after assessment.
- The registered manager did not assure that patient information was handled confidentially or stored securely.
- The service did not have an information sharing policy which ensured that relevant patient information was communicated amongst staff.
- The service had not followed up on some identified actions in its fire risk assessment.
- The service did not have records or evidence that some faculty members had received an appraisal.

Summary of findings

Contents

Summary of this inspection

	Page
Background to The Child and Family Practice	5
Our inspection team	5
Why we carried out this inspection	5
How we carried out this inspection	5
What people who use the service say	6
The five questions we ask about services and what we found	7

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards	9
Overview of ratings	9
Outstanding practice	17
Areas for improvement	17
Action we have told the provider to take	18

Good



The Child and Family Practice

Services we looked at

Community-based mental health services for adults of working age; Specialist community mental health services for children and young people;

Summary of this inspection

Background to The Child and Family Practice

The Child and Family Practice is a community-based independent health service that specialises in the psychological wellbeing and mental health of children, young people and adults. The service accepts self-referrals in addition to referrals from medical insurers, GPs and other mental health practitioners from across the country and internationally. The service conducts multi-disciplinary child and adolescent mental health assessments and provides treatment. They also provide family and couple therapy, educational consultancy and family mediation. The majority of patients are child and adolescents but the service would also see adults of working age.

The majority of staff were not employed directly by the service and hired rooms on a sessional or adhoc basis to provide services. This includes psychiatrists,

paediatricians, psychologists and occupational therapists. These contracted staff are expected to obtain supervision and appraisals outside of the Child and Family Practice.

The organisation is a limited company with a board of directors and 12 shareholders. The registered manager is the chair of this board. The registered manager has a clinical background as a consultant psychiatrist whilst the medical director has a background as a consultant paediatrician.

This was our first inspection of the service since it registered with CQC in December 2015. The service is registered to provide the regulated activity:

Treatment of disease, disorder or injury.

Our inspection team

The team that inspected the service comprised a CQC inspector and a specialist advisor. The specialist advisor was a consultant psychiatrist with a background in child and adolescent services.

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?
- 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, looked at the quality of the environment and observed how staff were caring for patients
- spoke with the registered manager and two senior managers for the service
- spoke with an administrator

Summary of this inspection

- received feedback about the service from one patient using comment cards
- looked at four care and treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We were unable to get any direct feedback from patients during our inspection. We asked patients if they wished to speak with CQC inspectors, however our requests were turned down.

We did receive positive feedback about the service through one comment card. The patient spoke of kind

and considerate staff and found the service responsive and personalised. Additionally, the service collected feedback through an anonymous survey after each appointment. The majority of this feedback was positive with most patients very satisfied with their experience.

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?

Good



We rated safe as **good** because:

- The environment was clean, tidy and well maintained.
- Staff had completed the required mandatory training and continuous professional development.
- Staff received safeguarding training and knew how to make a safeguarding alert.
- The service had a clear incident reporting procedure in place and staff knew how to report an incident.
- Staff ensured patients had nominated clinicians to cover their caseloads.
- The service had conducted appropriate recruitment checks for all staff.

However:

- The service did not follow up on some identified actions in its fire risk assessment.

Are services effective?

Good



We rated effective as **good** because:

- Staff were skilled and experienced. The team included a wide range of professionals including psychiatrists, psychotherapists, family therapists, paediatricians, occupational therapists and psychologists.
- Staff met on a regular basis to discuss caseloads, complex cases, ongoing treatment and referrals.
- The service conducted specialist multi-disciplinary assessments with input from a range of different professionals.
- The service offered psychological therapies in line with NICE guidance.
- Educational consultants supported staff, patients and families with communication between schools.
- The service ran a physical health service for patients where there were concerns about their health and wellbeing.
- Specialist dietitians supported patients with eating disorders with nutrition and eating plans.

However:

- The service did not ensure that all faculty members had received an appraisal.

Summary of this inspection

Are services caring?

Good



We rated caring as **good** because:

- Staff treated patients with respect and care.
- The provider's patient feedback survey demonstrated that the majority of patients were either satisfied or very satisfied with their experience using the service and would recommend it to their friends or family.

Are services responsive?

Good



We rated responsive as **good** because:

- The service had clear target times for responding to referrals. Staff consistently met targets to see urgent appointments within 24 hours.
- The service had a clear complaints process. There had been no complaints within the previous 12 months.
- The service ensured patients with mobility issues could access the service.
- The service was flexible in its approach to arranging appointments. The service ensured appointments were available in the evening and on weekends.

Are services well-led?

Requires improvement



We rated well-led as **requires improvement** because:

- Governance arrangements were not sufficiently robust. Quality assurance processes for record-keeping and risk management were not in place. The registered manager did not have access to faculty member's patient care records and did not ensure they were accurate, up to date and that identified risks were identified and managed.
- The service did not ensure that patient information was handled and stored securely.

However:

- The service had systems in place to ensure that learning from incidents and complaints was shared amongst staff at multi-disciplinary meetings.
- Staff morale was good and staff were happy working in the service.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

- All permanent staff members had completed training in the Mental Capacity Act (MCA). Faculty members were expected to have MCA training as part of their continuing professional development. Staff had a good understanding of the Mental Capacity Act.
- Staff could refer to a policy on the Mental Capacity Act. If staff had a reason to doubt a patient's capacity they could access this policy for guidance.
- Patients voluntarily approached the service for treatment and were presumed to have the capacity to consent. Staff assessed capacity to consent to treatment if they had reason to believe the patient lacked capacity. We reviewed four records that demonstrated patients had given consent prior to treatment. Staff had conducted decision specific assessments and the best interests of the individual considered. However we were unable to review contracted staff's patient records to confirm this occurred with all patients.
- Staff had a good understanding of Gillick competence. Gillick competency is where a person (under 16 years of age) is assessed and deemed to have the competence to make decision about their own care, without the need for parental consent. For patients under the age of 16, staff applied the Gillick competency test. Competency of patients was clearly assessed and recorded






Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Specialist community mental health services for children and young people	Good	Good	Good	Good	Requires improvement	Good
Overall	Good	Good	Good	Good	Requires improvement	Good

Specialist community mental health services for children and young people

Good 

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

Are specialist community mental health services for children and young people safe?

Good 

Safe and clean environment

- The service was located in a four story building. There were ten rooms available for consultations. Patients accessed the building through an intercom system managed by receptionists.
- Domestic staff cleaned the building every day. The environment was clean and tidy. Staff adhered to infection control principles and handwashing posters were located in toilets.
- The service completed a fire risk assessment in July 2015 which identified a number of areas for improvement for the next recommended fire risk inspection. Issues included portable appliance testing, storage of combustibles, a lack of records for fire drills, extinguishers not periodically maintained, unsafe panelling and unallocated emergency roles. The provider had developed an action plan to improve the majority of identified issues, however some areas remained unaddressed. For example, the provider did not have records of fire drills.
- The service did not have a clinic room as staff did not carry clinical procedures on site. Some consultation rooms contained weighing scales which the supplier had serviced in the previous 12 months.

Safe staffing

- The service maintained safe levels of staffing that met the needs of patients. Four staff worked on a permanent basis and managed the business and operations functions across the service. We observed that patients had access to 46 clinicians that were not employed directly by the service and hired rooms on a sessional or adhoc basis to provide services. The service ensured that patients did not have to wait for appointments and the numbers of staff available were appropriate to ensure the service operated well
- The service employed a full time registered manager, who was also the chair of the organisation, a medical director and an administrator. The registered manager and medical director worked as full time clinicians at the service and had a clinical background as a consultant psychiatrists and consultant paediatrician. Other members of the team included part time receptionists.
- A pool of professionals provided services on a sessional or adhoc basis. This staff group consisted of 12 consultant psychiatrists, 13 psychologists, five psychotherapists, three family therapists, three educational consultants, three dietitians, two paediatricians, one occupational therapists, one physiotherapist, one family mediator, one audiological physician and a speech and language therapist. Patients were allocated according to their presentation and needs.
- The service ensured there were cover arrangements in place for when clinical staff were on leave.

Specialist community mental health services for children and young people

Good 

- The service completed appropriate recruitment checks for all staff. We reviewed seven employment records and found that all staff had provided appropriate references and had undergone disclosure and barring checks (DBS).
- Faculty members provided evidence of professional indemnity insurance, evidence of membership to professional organisations and a code of conduct.
- The provider ensured that permanent staff had completed the required mandatory training. This included fire safety training, first aid training and basic life support training. Permanent staff had completed all training modules at the time of our inspection. Staff working on a sessional basis were required to send in continuous professional development records to show completion of training. We reviewed the records of seven faculty members. The records demonstrated evidence of regular mandatory training.
- Permanent staff we spoke with knew how to make a safeguarding alert. The service had a policy in place for safeguarding children and adults. However we were unable to speak with faculty members regarding their awareness of the service's safeguarding policy and their individual safeguarding responsibilities. Safeguarding adults and children training was mandatory for permanent staff, and all had completed this. For faculty members, the seven records we reviewed demonstrated that all had completed the appropriate safeguarding adults and children training.
- The service also had monthly child protection meetings for child and adolescent psychiatrists. Staff discussed and monitored the progression of existing safeguarding referrals in addition to new safeguarding alerts raised by staff.

Assessing and managing risk to patients and staff

- The service did not accept patients with a high level of risk or if they were unable to meet their needs. On referral to the service the registered manager gathered background information about the patient and approached other professionals, for example the patient's GP for further information. The registered manager would then allocate to an appropriate member of the staff team for assessment.
- The service did not use alarms in consultation rooms as they did not take on high risk patients. Staff were aware of the level of risk patients had when they arranged appointments.
- We were unable to view patient records maintained by faculty members as the registered manager did not have access to these records and we could not determine if faculty members were appropriately assessing and managing risks. We escalated this to the registered manager during the course of our inspection. However, we reviewed four patient records maintained by the registered manager and the medical director. These risk assessments were comprehensive and documented potential risks and the measures in place to mitigate these appropriately, for example, risk of self-harm or harm to others.
- The service did not store, transport or administer medicines.

Track record on safety

- The service defined a serious incident as any that caused serious concern or potentially put a patient at risk of significant harm. The service had two serious incidents in the previous 12 months. These related to a physical health emergency and an incident involving harm to a relative. Both incidents resulted in a robust investigation with appropriate identified learning. The registered manager investigated the first serious incident and determined staff had acted appropriately by performing emergency physical health checks and calling an ambulance. The medical director investigated the second serious incident and determined that service was not directly responsible. The service offered support and liaised with local NHS services to follow up the investigation. Learning from both incidents was shared with both permanent and contracted staff at the multi-disciplinary meeting where identified actions and outcomes were discussed amongst the team.

Reporting incidents and learning from when things go wrong

- The service had a clear incident reporting procedure. The administrator documented all incidents in an incident log book. Staff we spoke with understood what constituted an incident and what they needed to be report. If incidents occurred, the service escalated this for discussion at multi-disciplinary meetings to ensure learning amongst staff.
- The duty of candour is a legal requirement, which means providers must be open and transparent with

Specialist community mental health services for children and young people

Good 

patients about their care and treatment. This includes a duty to be honest with patients when something goes wrong. Whilst staff could articulate the duty of candour and it was written down in a policy, there were no incidents that required a duty of candour response. Permanent staff were aware of the need to be open.

Are specialist community mental health services for children and young people effective?

(for example, treatment is effective)

Good 

Assessment of needs and planning of care

- In the four records we were able to view, the service offered a range of assessments dependent upon patient need. A multi-disciplinary assessment for children and adolescents consisted of three different stages. The first stage comprised a clinical assessment conducted by a neurodevelopmental paediatrician and reviewed all medical and educational reports the patient had undergone prior to the multi-disciplinary assessment. This also included a comprehensive physical examination. The second stage consisted of a diagnostic process including a series of specialist consultations. This could include psychometric profiling, psychiatric assessment, motor performance assessment, speech and language assessment, sensory processing assessment and psycho-emotional assessment. The third stage comprised a feedback meeting with parents and fed back diagnoses, a management plan and an individual educational plan and liaison with the child's school with one of the senior educationalists on the team.
- We were unable to view faculty member's patient records. We viewed four patient records the registered manager and medical director had completed. We saw they had conducted initial multi-disciplinary assessment with treatment plans that outlined the type of recommended treatment. The assessment outcome was recorded comprehensively in a letter sent to patients and their GPs. This included the patient's psychiatric and medical history, level of risk, social situation, substance misuse, recommendations for treatment and mental capacity.

Best practice in treatment and care

- Psychiatrists followed safe prescribing practices that followed National Institute for Health and Care Excellence (NICE) guidelines. We reviewed four patient records and found that prescribing was within recommended dose limits.
- The multi-disciplinary team included psychologists who could see patients and their families. The psychologists offered NICE recommended therapies such as cognitive behavioural therapy and psychotherapy to support patients. Contracted psychologists could also assess child and adolescents for presenting difficulties such as adjustment to divorce and family breakup, communication disorders, physical illness, bereavement and loss, accident trauma and emotional and behavioural disturbance at schools.
- During our inspection we were unable to speak to faculty members and as a result we were unable to see evidence in regards to some of the work faculty members undertook. Additionally we were unable to access faculty members' patient records. However the service informed us in regards to areas of best practice they undertook. The service explained that they offered speech and language therapy alongside other treatment. Staff further explained that they saw children and young people for evaluation and advice regarding delays in speech and language development, speech sound production difficulties and disorders social communication. However we were unable to see evidence of this during our inspection.
- The service informed us that Educational consultants supported staff with communication amongst patients, parents and schools. This was to ensure close liaison with schools and support parents with moving children between schools. Educational consultants were experienced and had previously worked as heads of education in schools.
- Staff carried out some physical health checks such as height and weight for patients prescribed medicines. The service also recommended patients to have more comprehensive physical health checks via patients GPs. We observed through our review of records that when this occurred, staff sent letters followed up by direct communication through email or telephone.
- Faculty members included specialist dietitians to educate patients with eating disorders on nutrition and

Specialist community mental health services for children and young people

Good 

advice on eating plans. This included drawing up eating plans and setting goals to support patients with their recovery gains, for example, weight gain or maintenance and improving nutritional adequacy.

- The service had conducted an audit for the number of child and adolescent cognitive assessments that came through the multi-disciplinary assessment process in 2017. The service was in the early stages of collecting data regarding patient outcomes.

Skilled staff to deliver care

- Faculty members included paediatricians, psychotherapists, psychiatrists, psychotherapists, family mediators, psychologists, speech and language therapists, educational consultants and occupational therapists.
- The service had arrangements in place to ensure permanent staff received supervision on a regular basis. The medical director received supervision outside of the service at a local NHS children's hospital.
- Faculty members were responsible for arranging their own external supervision. The administrator for the service requested and maintained records of faculty members supervision to ensure staff were receiving regular supervision. Contracted staff received additional clinical supervision through weekly team multi-disciplinary meetings.
- Faculty members were responsible for ensuring they completed an appropriate annual appraisal that included their work with the service. Faculty members were required to submit their annual appraisal to the service. However for four of the seven employment records we checked, there was no evidence that this had occurred.

Multidisciplinary and inter-agency team work

- The service held a weekly multi-disciplinary assessment meeting. Faculty members who were involved in the cases being discussed at the meeting either attended the meeting or dialled in to listen. Staff used the meeting to discuss multi-disciplinary cases and recommend follow up therapies for patients. The administrator would forward on outcomes and actions of this meeting via email to other faculty members.
- Where other providers were involved with a patient, for example, local community mental health services or GPs, staff copied them into correspondence or contacted them via emails and telephone calls.

- The service had a monthly faculty meeting. Staff used this meeting to discuss clinical governance and operational issues. Additionally, clinicians would present a theme for discussion, for example on mediation, family cases or attention deficit hyperactivity disorder (ADHD). The minutes of meetings we reviewed showed that recent discussions had included recruitment or referrals to other providers.
- At the time of the inspection, communication among staff regarding patients within the service was through emails and telephone calls. The service shared recommendations from assessments and appointments via this system and expected staff to follow this up. However this was not stored in patient records and we did not see evidence how the registered manager could access care records when the clinician was unavailable.

Good practice in applying the MCA

- All permanent staff members had completed training in the Mental Capacity Act (MCA). Faculty members were expected to have MCA training as part of their continuing professional development. Staff had a good understanding of the Mental Capacity Act.
- Staff could refer to a policy on the Mental Capacity Act. If staff had a reason to doubt a patient's capacity they could access this policy for guidance.
- Patients voluntarily approached the service for treatment and were presumed to have the capacity to consent. Staff assessed capacity to consent to treatment if they had reason to believe the patient lacked capacity. We reviewed four records that demonstrated patients had given consent prior to treatment. Staff had conducted decision specific assessments and the best interests of the individual considered. However we were unable to review contracted staff's patient records to confirm this occurred with all patients.
- The four permanent staff we spoke with had a good understanding of Gillick competence. Gillick competency is where a person (under 16 years of age) is assessed and deemed to have the competence to make decision about their own care, without the need for parental consent. For patients under the age of 16, staff applied the Gillick competency test. Competency of patients was clearly assessed and recorded.

Specialist community mental health services for children and young people

Good 

Are specialist community mental health services for children and young people caring?

Good 

Kindness, dignity, respect and support

- During the inspection we observed staff treating patients with respect and care. We observed staff speaking with patients and carers on the telephone in a respectful and polite manner.
- Staff supported patients to understand and manage their care, treatment or condition. The service took a personalised approach to take account of patient's preferences and choices for treatment.
- Staff had a good understanding of the individual needs of patients. Staff discussed patient's social and cultural backgrounds upon admission to the service.
- We received feedback from one comment card. The feedback was positive and the patient felt staff were kind, helpful and considerate. We were unable to receive direct feedback from patients during our inspection as they did not want to speak with our staff during the inspection.

The involvement of people in the care they receive

- Patients and families were encouraged to give feedback about their experience. The service asked patients and families to give feedback through a feedback form after each consultation. The survey looked at patient satisfaction in regards to their experience at the service and if they would recommend the service to family and friends. A review of 38 feedback forms evidenced that the majority of patients were either satisfied or very satisfied with their experience and were likely to recommend the service to friends and family.

Are specialist community mental health services for children and young people responsive to people's needs? (for example, to feedback?)

Good 

Access and discharge

- The service received self-referrals in addition to referrals from GPs, corporate companies and insurers and other mental health practitioners. The majority of referrals were self-referrals. Just over 60% of referrals were from within the United Kingdom. The remaining 40% came from outside the country. On a weekly basis 10 to 15 referrals were received for specialist assessments by an individual discipline. Between eight to ten referrals were received each week for multi-disciplinary assessment.
- On referral to the service the registered manager would triage referrals to decide to refer the referral to the multi-disciplinary assessment team or refer it on to a specific contracted clinician. The registered manager screened referrals to ensure the service could meet patients' needs and allocated these to a member of the multi-disciplinary team.
- The service had clear target times for responding to referrals. Once the service accepted a referral, staff had a target of arranging an appointment within 24 hours. The service consistently met these target times.
- The service did not have a waiting list and ensured that patients were able to access an appointment within 24 hours. For international patients, staff ensured that they arranged appointments to coincide with their visit to the UK.
- For the records we looked at, the service sent out the assessment letter within the UK within seven days of the appointment unless there were specified physical health checks such as blood tests.

The facilities promote recovery, comfort, dignity and confidentiality

- The service had ten consultation rooms to support treatment. Consultation rooms were adequately sound proofed for patient confidentiality.

Specialist community mental health services for children and young people

Good 

- Patients had access to leaflets in the waiting room that gave information on how to make a complaint and what services and types of treatment were available.

Meeting the needs of all people who use the service

- The building provided wheelchair access to patients. Staff had access to a ramp at the entrance and staff could see patients in consulting rooms on the ground floor.
- The service had a waiting room on the ground floor and at the top of the building.
- The service was open seven days a week from 8am to 8pm to meet the needs of patients.
- The service accepted many patients from different countries. If needed, staff were able to access external interpreters and gave patients the option of bringing their own interpreters.

Listening to and learning from concerns and complaints

- Patients knew how to make a complaint. The service gave information on how to make a complaint on acceptance to the service.
- The service had a complaints policy in place. There was a clear process for managing complaints.
- The service ensured they appropriately managed complaints. In the previous 12 months the service had received no complaints. The service kept a record of complaints, correspondence between the service and the patient and the final outcome. For complaints that could not be resolved within the service, the registered manager referred complaints to an independent adjudication service.

Are specialist community mental health services for children and young people well-led?

Requires improvement 

Leadership

- Leaders had the skills, knowledge and experience to perform their roles. The registered manager had a

background in child psychiatry and the medical director had a background as a paediatrician. They had a good understanding of the services they managed and were able to describe how they provided high quality care.

- The registered manager and medical director were approachable for both patients and staff. Staff could contact both the registered manager and medical director via telephone or email for advice and support. The registered manager attended the service on a daily basis.
- Senior managers at the service supported the administrator to complete further management and finance training.

Vision and strategy

- The provider outlined their core principles and commitments in their employee contract, which all staff signed before starting work at the service. Staff understood the aims of the service to provide a quality service responsive to people's needs.
- Permanent staff and faculty members both had the opportunity to contribute to discussions about the strategy of the service through multi-disciplinary team meetings. Staff were aware of the organisation's managers who ran the service on a day to day basis.

Culture

- Permanent staff we spoke with felt respected, supported and valued. Staff spoke positively about working for the service and felt the culture was open and transparent.
- Permanent and contracted staff worked well together and demonstrated a high level of respect for each other. The service welcomed views from all staff.
- Staff appraisals included conversations about career development and how managers could support staff.
- The registered manager dealt with poor performance when needed. The registered manager explained how they had taken action to remove a faculty member whose conduct did not correspond with the services values.

Governance

- The organisation was a limited company with a board of directors. The registered manager was the chair of this board. The registered manager met monthly with the board of directors to discuss operations and share information.

Specialist community mental health services for children and young people

Good 

- The service did not have appropriate systems to govern, monitor and ensure patient records were appropriately maintained, accurate or up to date. The service did not conduct regular reviews or audits of care and treatment records to maintain oversight or understand decisions taken by clinicians. Before our inspection we asked the registered manager to make contracted staffs' care and treatment records available. Whilst we were able to review the registered manager and medical directors care and treatment records senior managers did not regularly access or review faculty records to ensure the care and treatment delivered was appropriate or safe. However the service did have appropriate systems to ensure the premises were clean and that staff saw patients quickly and efficiently. The service ensured staff worked well in a multi-disciplinary format and addressed complaints and incidents with learning shared.
- Faculty members and permanent staff met on a regular basis to discuss referrals, good practice, safeguarding and complex cases.
- Staff undertook and participated in some local audits. Examples of audits related to referrals and follow up treatment.
- The service had systems to collect some data, and was not over-burdensome to staff. This included information on complaints, referrals and incidents. However patient information was not readily accessible to the registered manager.
- The service did not ensure that patient information was handled securely. The service did not have an information sharing policy that staff could refer to in relation to data protection and information governance. As a result the registered manager was unable to give assurance that faculty members securely stored patient records. Additionally, faculty members did not have a secure provider email to share information regarding patient care and treatment amongst each other.
- The administrator and registered manager had access to information about the service. This included turnover, sickness data and referral information and demographics.
- The registered manager made notifications to external bodies, for example the manager had reported notifications to the Care Quality Commission.

Engagement

- Staff, patients and carers could access information about the service through the organisation's website. This included information about treatment and staff who worked at the service. Patients also had the option to give feedback after each consultation or appointment.

Learning, continuous improvement and innovation

- Staff were not involved in research or national audits at the time of our inspection.

Management of risk, issues and performance

- Staff were able to escalate concerns to the registered manager. The service had a risk register and business continuity plan in case of emergencies. The main risks to the service related to staffing and the premises.

Information management

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure that systems and processes are in place to ensure that each clinician maintains an accurate, complete and contemporaneous record in respect of each patient. All staff that need to, must be able to access this.
- The provider must ensure that confidential patient information is handled securely.

Action the provider **SHOULD** take to improve

- The provider should ensure the service addresses actions fire risk concerns identified in the provider's most recent fire risk assessment.
- The provider should ensure that faculty members submit evidence of appraisals.

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	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>Systems and processes were not in place to ensure that each clinician maintained an accurate, complete and contemporaneous record in respect of each service user and the decisions taken in respect of each service user. Not all staff who needed to, were able to access patient's care and treatment records.</p> <p>The service did not ensure that confidential patient information was handled or stored securely.</p> <p>This was a breach of regulation 17 (2) (c)</p>