# Psychiatry-UK LLP

## Quality Report

Lowin House
Tregolls Road
Truro
Cornwall
TR1 2NA
Tel: 03301241980
Website: www.psychiatry-uk.com

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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** | **Requires improvement** |
| Are services safe? | Requires improvement |
| Are services effective? | Requires improvement |
| 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 Psychiatry-UK as requires improvement because:

- There was insufficient oversight and understanding of safeguarding procedures. Safeguarding policies and procedures lacked information to enable staff to make referrals to the local authority without delay. Staff did not all know how to make safeguarding referrals. Staff had not completed an appropriate level of training in safeguarding.
- Staff did not verify the identity of the person they were consulting with before starting the appointment and this meant there was a risk staff could prescribe medicines, record and share information about the wrong patient.
- Staff did not routinely record patients' consent to treatment or whether or not they had needed to assess the patient's capacity to consent to their treatment. The provider did not ensure all staff were trained in the Mental Capacity Act.
- Psychiatrists did not always record patients' current or historical risks in patients records or in letters to GPs. Staff did not always develop and document crisis plans with patients.
- There were limited opportunities for staff to discuss their work, service development and learning from incidents and complaints.
- There were limited ways to monitor psychiatrists' work, answer questions and provide support as the provider did not offer formal induction, supervision or team meetings to staff. Some staff did not have appraisals that were specific to their work with Psychiatry-UK. There was a lack of oversight and monitoring of the quality of consultations and the provider had not developed systems and processes to enable them to performance manage staff.
- Although the provider took steps to store care records securely, information such as letters to GPs needed to be stored locally in order for psychiatrists to edit them and this presented a risk to the security of patient information.

However

- The provider was well staffed and there were no waiting times. Patients could choose which psychiatrist they consulted with and appointments were available at a range of times. Patients said the service was easy to access.
- Patients gave good feedback and said staff were kind and respectful. Patients said they were involved in decision making about their care. Patients could include their families in their care if they wanted to and carers said they felt supported and involved.
- Psychiatrists completed a comprehensive assessment during the first appointment with each patient. They used nationally recognised scales to help them make accurate diagnoses. Assessments were personalised, holistic and recovery-oriented.
- Staff made shared care arrangements with GPs to ensure physical health monitoring was in place.
- The provider was keen to develop the service and they took part in the development of new approaches. There were opportunities for specialist psychiatrists to develop the service they offered.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Community-based mental health services for adults of working age** | Requires improvement  | Psychiatry-UK provided online consultations by tele-conference with psychiatrists to fee-paying patients including assessments and prescriptions |

# Summary of findings

## Contents

Requires improvement

# Psychiatry-UK

**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. The provider comprises a group of consultant psychiatrists who are listed on the specialist register at the General Medical Council. Psychiatrists provide remote mental health advice, consultations, prescriptions and information services. The service provides support to patients of all ages from the age of ten upwards. They provide consultations on a variety of presentations including general child, adult and older adult psychiatry, perinatal conditions, addictions and eating disorders. The service is provided to people who pay privately for it.

Most patients who consulted the service suffer from depression or anxiety disorders. Most patients are adults with about 10% being children. Half of the adults consulting the service did so for attention deficit hyperactivity disorder.

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 the first inspection of the service.

## Our inspection team

The team that inspected the service comprised two CQC inspectors, an assistant inspector, a psychiatrist and a pharmacist specialist.

## 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:

- spoke with six patients who had used the service
- spoke with three and received feedback from two carers of children who had used the service
- spoke with the registered manager
- spoke with six other staff members including psychiatrists and the chief operating officer
- attended and observed a team meeting
- received feedback through our website 'share your experience' link from 25 patients
- looked at 10 care and treatment records of patients
- carried out a specific check of prescribing practices
- looked at a range of policies, procedures and other documents relating to the running of the service.

# Summary of this inspection

## What people who use the service say

Patients described Psychiatry-UK services as professional and they said they received good quality care.

Patients told us staff were caring and respectful. They said they had confidence in and felt involved in the decisions made about their care. Out of 25 people who wrote to us, 21 said the provider asked them for their views on the quality of the care provided by the service.

Patients said the service was easy to access and they appreciated being able to speak to a psychiatrist from home. They found it easy to book an appointment and liked being able to email psychiatrists.

Patients said they were given information about their condition and the treatment they were offered. They said the service sent timely follow up letters to their GP. However, some patients said their GPs did not always act on the service's recommendations.

Some patients did not know how to complain and thought this had not been explained to them.

Everyone we spoke to or heard from said they would recommend the service.

# 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?

Requires improvement

We rated safe as requires improvement because:

- Psychiatrists did not always detail patients' current and historical risks in patients records. This was the case in two out of ten records we reviewed. The providers own audit showed letters to GPs did not always include information about risk. Staff did not always develop and document crisis plans with patients.
- At the time of our inspection the provider did not have measures in place to verify the identity of the person they were consulting with. There was a risk staff could prescribe medicines, record and share information about the wrong patient. The provider told us they planned to implement a method following our inspection.
- The provider did not have clear and detailed safeguarding policies and procedures to enable staff to make referrals to the local authority without delay.Staff had not completed training in safeguarding adults and children to an appropriate level.
- The provider did not have systems in place to monitor prescribing and they did not complete any prescribing audits. There was no central monitoring of the dispatch of prescriptions to patients.

However

- The provider was well staffed with appointments available as soon as the next working day for patients.
- Staff shared information with the patients' GPs in order to keep them informed and to ensure the GP could provide monitoring and ongoing prescribing where appropriate. They consulted with GPs before offering appointments to families for children.
- Staff responded to emergencies appropriately and informed patients via their website about what to do if they needed urgent help.

### Are services effective?

Requires improvement

We rated effective as requires improvement because:

- The induction procedure was not formalised.
- Staff did not routinely attend team meetings and this meant there were limited opportunities for them to discuss and develop their work and for them to take part in discussions about and learning from incidents and complaints.

# Summary of this inspection

- Psychiatrists that regularly worked for Psychiatry-UK and also worked in the NHS did not have an appraisal specific to their work with Psychiatry-UK.
- The provider did not provide formal supervision for psychiatrists working in the service. There were two optional specialist peer group supervisions for those with a special interest in attention deficit hyperactivity disorder and those who worked with children but these were specialist closed groups.
- Staff did not routinely record patients' consent to treatment or whether or not they had needed to assess the patient's capacity to consent to their treatment.
- Although the provider took steps to store care records securely, information such as letters to GPs needed to be stored locally by psychiatrists on their own device if they needed to edit them. This presented a risk to the security of patient information.

However

- Psychiatrists completed a comprehensive assessment during the first appointment with each patient. Assessments were personalised, holistic and recovery-oriented.
- To ensure they completed a thorough assessment, psychiatrists consulted with the GPs of children and other relevant organisations such as social services before meeting with the child or young person.
- Psychiatrists used nationally recognised scales to rate symptoms when conducting attention deficit hyperactivity disorder assessments for adults to help them to make accurate diagnoses.
- Psychiatrists included physical healthcare needs in their assessment of each patient. Physical health checks were undertaken by the patient's GP. However, psychiatrists sometimes enabled patients to monitor their own blood pressure and send the results in for review and they also reviewed patients' blood tests if appropriate.

## Are services caring?

Good

We rated caring as good because:

- Patients gave good feedback about the service and said staff were kind and respectful.
- Patients said they were involved in decisions that were made about their care. Patients could include their families in their care if they wanted to and carers said they felt supported and involved.

# Summary of this inspection

- There were a variety of ways for patients to give feedback about the service. The provider reviewed and responded to feedback and made improvements to the service.

## Are services responsive?

Good

We rated caring as good because:

- Patients could choose which psychiatrist they consulted with and they usually had an appointment within a week. Appointments were available at a range of times to suit patients.
- Patients could access the service from a place to suit them. The provider developed applications to enable patients to access the service through a variety of devices including mobile phones.
- The provider gave patients information about national services for use in an emergency.
- The provider helped people with disabilities and people who spoke foreign languages to access the service.
- The provider acted on complaints to develop the service and fed back the outcomes to the team via a newsletter.

However

- Staff were unclear about the lower age limit for the service.

## Are services well-led?

Requires improvement

We rated well-led as required improvement because:

- There was a lack of oversight and monitoring of the quality of consultations and the provider did not have policies to enable them to performance manage staff.There were limited ways to monitor psychiatrists' work, answer questions and provide support as the provider did not offer supervision or team meetings for staff.
- There was a lack of oversight of the safety of the service. Safeguarding procedures were not clear and staff did not have a consistent procedure for making safeguarding referrals.
- The provider's risk register needed developing because it lacked active mitigation to prevent or reduce risks.
- The service lacked sufficient clinical management capacity and was dependent on the registered manager/medical lead and chief operating officer for its governance and leadership. The service was growing and there were plans to appoint a deputy.

# Summary of this inspection

- The whistle-blowing policy did not include information about the sorts of concerns staff could raise, the protection afforded to employees such as confidentiality or the procedure for handling and investigating concerns.

However

- The provider monitored incidents and complaints and acted on the learning to improve the service.
- Staff morale was good and there were opportunities for specialist psychiatrists to develop the service they offered.
- The provider was undertaking cyber essential accreditation and adopting national standards as a means of strengthening their approach to keeping sensitive information.
- The provider took part in the development of new approaches to treatments for treatment resistant depression in collaboration with other providers.

# Detailed findings from this inspection

## Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider did not check that staff were up to date with training in the Mental Capacity Act.
- 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. We looked at ten care records and found that in two cases mental capacity had been assessed.
- The provider told us that patients who are assessed as having impaired capacity would be excluded from the service and directed to an alternative appropriate for the provider.
- 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.

## 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** | Requires improvement | Requires improvement | Good | Good | Requires improvement | Requires improvement |
| **Overall** | Requires improvement | Requires improvement | Good | Good | Requires improvement | Requires improvement |

Requires improvement

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

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

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

Requires improvement

### Safe and clean environment

- Psychiatry services were provided remotely over the internet by psychiatrists working from their own premises. The appointments took place using video conferencing using the provider's encrypted bespoke video conferencing system. 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 32 consultant psychiatrists, a business manager, a chief operating officer, a founder, an investor, a business advisor and an investment partner who was also the medical lead and registered manager. There were 22 psychiatrists that specialised in adult psychiatry and seven that specialised in child and adolescent psychiatry. The provider had appointed a nurse practitioner who was not yet in post. The aim was for the nurse to support the administration of prescriptions.
- The provider did not monitor sickness rates. They asked psychiatrists to remove their availability from the appointments system if they were sick. There were no formal cover arrangements.
- There were no vacancies for the service.
- The provider did not employ agency staff.
- The provider did not manage or review caseloads as they were below that which would cause them any concern.
- The overall compliance rate for mandatory training was 93%. Equality and diversity training had been completed by 71% of eligible staff. The provider asked those psychiatrists who worked for the NHS to provide proof they had completed mandatory training through the NHS. The provider offered mandatory training to the remaining psychiatrists.
- The provider had a professional standards policy but it required some updating, for example it referred to criminal records and barring service which has been replaced by the disclosure and barring service since 1st December 2012. Psychiatry-UK accepted criminal records and barring service checks undertaken by other organisations.

### Assessing and managing risk to patients and staff

- We looked at ten care records.
- Psychiatrists did not use a risk assessment tool for assessing risk. Although all ten of the records we looked at had up to date risk assessments, in two cases risks were not fully detailed. The provider had completed their own audit of the information contained in letters their psychiatrists had written to GPs about patients. They found five out of the 12 letters to GPs they sampled did not include historical risk of self-harm and in one out of 12 records current suicidal thoughts or intent was missing. Following the audit, the provider wrote to all the psychiatrists reminding them to consider recording previous and current suicidality for all patients. They plan to conduct the audit again in 2018.
- Psychiatrists were not consistently creating and recording crisis plans for patients that needed them.

- 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 had not ensured staff were clear on how to make safeguarding alerts and psychiatrists were unclear on the procedure. The procedure was to inform the medical lead if there were a child safeguarding concern. For vulnerable adults, the policy referred to managers having up to date information about how to refer to social services in different localities but this was not in place. One psychiatrist said if they needed to make a referral to the local authority they could look up the contact details on the internet and inform the patient's GP. One psychiatrist said they would ask the GP to make the referral. Another psychiatrist said they were not aware of how to make a safeguarding alert.
- All psychiatrists had completed levels one and two training in safeguarding for adults and children. However, due to the nature of their work, the provider agreed staff should also complete level three safeguarding training. The provider decided to make this mandatory following our inspection.
- The provider had two safeguarding policies, one for adults and one for children. The policies did not include modern slavery, self-neglect, domestic violence or organisational abuse and there was a lack of detail about responding to suspicions or concerns about someone's safety.
- 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. The team then made a decision about whether or not an appointment was appropriate. If a child was highly suicidal, for example, the psychiatrist would refer them back to urgent or emergency services.
- At the time of our inspection the provider did not have systems or processes to identify the patient at the start of the first and subsequent consultations. This meant there was a risk staff could prescribe for the wrong person. There was a risk they could record and share information with GPs and other healthcare professionals about the wrong person. There was a risk staff could make decisions without sufficient knowledge of the patient's history if they had given the wrong identity. The provider did not have systems and processes in place to effectively identify and mitigate the risks of patients holding multiple separate accounts with them. Following our inspection, the provider planned to implement a method of requesting patients to present photographic identity at the beginning of the consultation. One psychiatrist told us they already did this but a procedure had not been adopted across the service at the time of our inspection.
- 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.
- There was an up to date medicines management policy. The provider did not have systems in place to monitor or audit prescribing. When asked, the medical lead gave a rationale for the prescribing of specific items including ensuring arrangements were in place for physical health monitoring and blood testing where needed.
- There was no central monitoring of the dispatch of prescriptions to patients and each psychiatrist did this individually. Patients could receive prescriptions to their home address or a pharmacy of their choice. If a psychiatrist prescribed a controlled drug then it was sent out by signed for delivery.
- 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

Requires improvement

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

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.

- Psychiatrists did not usually prescribe for patients that lived outside the UK or for those who were not registered with a UK GP.

**Track record on safety**

- The provider had never had any serious incidents. However, the registered manager told us about an incident that did not meet the criteria for a serious incident that they intended to investigate because it was significant and concerned patient safety.

**Reporting incidents and learning from when things go wrong**

- Staff were aware of the need to report incidents. They reported incidents through an incidents email address that was monitored by the medical lead and chief operating officer or through the administration team or medical lead directly. The medical lead completed the investigation and consulted with the management team during weekly meetings. The procedure for reporting incidents was detailed in the provider's policy.
- Staff gave examples of incidents they would report including clinical incidents and information technology incidents. During our inspection, the provider told us of plans to report any deviation from National Institute for Health and Care Excellence guidance.
- 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, complaints and attendance at a team meeting. 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.
- Staff received feedback from investigation of incidents and changes that came out of them through a quarterly newsletter. Individual incidents were discussed with relevant staff as required
- The medical lead offered debrief to staff following incidents.

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

(for example, treatment is effective)

Requires improvement

**Assessment of needs and planning of care**

- Psychiatrists completed a comprehensive assessment during the first appointment. Our review of ten patient records showed assessments were up to date, personalised, holistic and showed an emphasis on recovery-oriented care. There was no standard assessment for the psychiatrists to complete. However, the registered manager told us all psychiatrists were trained to completed 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.
- The General Medical Council permits psychiatrists to prescribe for patients without a face to face meeting providing they are confident they have completed a thorough assessment.
- 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 history the provider obtained previous reports and letters. We spoke to a specialist child and adolescent consultant psychiatrist and they assured us of their confidence that they obtain all the information they need prior to prescribing for a child.
- Psychiatrists consulting patients for attention deficit hyperactivity disorder received information about patients in advance of their assessment. For example, the patient completed the Wender Utah scale that rates childhood symptoms. This was to ensure any diagnosis they made was accurate.

- The provider stored all its care records electronically on a bespoke patient management system. Staff said they had access to records when they needed it. However, they had to download letters to their personal devices in order to edit them.
- 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 encryption and firewalls. This was to ensure they preserved patients' confidentiality. The provider commissioned external testing of its server to assure 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. Most information was stored and edited online but psychiatrists had to save letters to their personal device in order to edit them. The provider advised staff to delete information they saved to their personal devices after use. The provider was aware this posed an information governance risk and they were investigating a solution.

**Best practice in treatment and care**

- Psychiatrists followed guidance issued by the National Institute for Health and Care Excellence when prescribing medication in most cases and provided a rationale when they deviated from guidelines.
- 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.
- During consultations, psychiatrists covered a variety of patient needs including, where relevant, physical health, lifestyle, relationships, school and employment. For example, if a patient was not sleeping well they would offer sleep hygiene advice. They also considered biological and genetic aspects to patients' difficulties.
- Psychiatrists included physical healthcare needs of each patient in their assessment but physical health checks were undertaken by the patient's GP. For example, psychiatrists working for the provider sometimes prescribed antipsychotic medicines and lithium by working alongside the GP to undertake physical health monitoring. If a not treated condition emerged during a consultation, the psychiatrist would suggest the patient consult with their GP.
- 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 attention deficit hyperactivity disorder 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 members of the quality improvement group had completed an audit of recording about suicidality in patient records. The audit was designed in response to a journal article about the information GPs want to receive from psychiatrists. The audit showed a 90% completion rate of information GPs would like to receive. The provider had recently commissioned an audit of pre-employment checks. These audits resulted in recommendations and an action plan that were discussed in the management team and informed all staff.

**Skilled staff to deliver care**

- The service was run by psychiatrists. The provider had appointed a nurse prescriber but they did not offer any other mental health disciplines. All the psychiatrists appointed to the service worked or had previously worked as consultant psychiatrists in the NHS.
- 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. The provider was aware induction procedures were not formalised or monitored. For example, an audit completed by the provider showed not all staff had read the consultation manual. Since the audit, the provider had addressed the findings with staff by holding one-to-one conversations, including items in newsletters and discussing the findings at their annual general meeting.
- The provider did not provide formal supervision for staff. There were two optional specialist peer supervision groups for those with a special interest in attention

deficit hyperactivity disorder and those who worked with children. The registered manager told us there was good peer supervision whereby if they had particular questions, psychiatrists could ask their peers for advice

- The appraisal rate was 100% for all staff and appraisals included consideration of specialist training needs. However, psychiatrists that worked in the NHS provided the medical lead with their NHS appraisal and revalidation. The medical lead read the appraisals but did not have a specific discussion with the member of staff about their development and training needs. Staff that no longer worked in the NHS had their appraisals and revalidation completed by a designated body they were required to join.
- The provider held weekly management team meetings and monthly meetings attended by the medical lead, chief operating officer, business development lead and three designated members. Staff did not regularly attend team meetings and this was not a requirement.
- The provider did not have a staff performance policy or procedure. However, there were examples where the registered manager had tackled performance issues with psychiatrists.

**Multi-disciplinary and inter-agency team work**

- 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.
- Psychiatrists made contact with other agencies to aid their work with patients and to pass on important information such as degree of risk. In particular, when consulting with children, the psychiatrists also worked with schools, social workers and other professional bodies.

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

- Training in being an approved clinician for section 12 of the Mental Health Act was completed by 76% of eligible staff. However, psychiatrists trained in the Mental Health Act as part of their core training. The provider did not offer a service to patients who were sectioned under the Mental Health Act.

**Good practice in applying the Mental Capacity Act.**

- The provider did not check that staff were up to date with training in the Mental Capacity Act.
- 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.
- The provider told us that patients who are assessed as having impaired capacity would be excluded from the service and directed to an alternative appropriate for the provider.
- 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.

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

Good

**Kindness, dignity, respect and support**

- Patients reported staff were kind and respectful. We received very positive feedback from patients that showed they were very satisfied with the service they received. 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.
- One member of staff offered a service free of charge.

**The involvement of people in the care they receive**

- Patients told us they felt involved in their care including decisions made about treatment and prescribing. 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.
- There were no specific mechanisms for involving patients in the development of the service.
- 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. The provider gave examples of times it had responded to feedback from patients, including

Requires improvement

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

clarifying the cost of private prescriptions and introducing an NHS funding application link on their website for patients to enable staff to apply for funding for clients' consultations on their behalf.

## 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 offer an urgent service but in many cases could see patients following day, depending on their difficulties, and usually within a week. If patients selected a particular psychiatrist, they sometimes had to wait longer than a week.
- The provider employed a service to provide administration for the service. 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 the NHS but encountered barriers. They told us Psychiatry-UK would not provide a service to patients who were at a high level of risk as it was not safe to do so. For example, patients suffering from a severe eating disorder, patients at risk of detention under the Mental Health Act or lacking mental capacity would be excluded. There was some confusion about the age range for the service with one psychiatrist saying they offered a service to children over 7 and the website saying the service was for patients over the age of ten.
- 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. Patients could usually access an appointment within a week. Patients could read about the psychiatrists and their specialisms on the website and choose which one they wanted to see. There were no complaints about appointments being cancelled or running late.

### 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.
- 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 provided created mobile applications to enable patients to do so.
- The provider did not have printed information in foreign languages. However, they employed several psychiatrists that spoke foreign languages and if they could they offered patients an appointment with someone who spoke their native language.

### Listening to and learning from concerns and complaints

- The provider had received three complaints in the 12 months previous to our inspection; two were upheld and none were referred to the ombudsman.
- The provider received 96 compliments in the past 12 months.
- 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.

Requires improvement

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

- Patients could complain via email or telephone. Psychiatrists did not actively inform patients about how to complain. Although most patients told us they would be willing to make complaints if they needed to, they told us they did not know how to do so.
- Complaints were discussed and reviewed in weekly meetings. Feedback and learning from complaints was shared with staff in the quarterly newsletter.

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

Requires improvement

### Vision and values

- The provider's aims were to safely offer an intelligent, cost-effective, high-quality consultant-led medical service making full use of modern technology to offer accessible, reliable, timely, trustworthy on-line consultations using a video conferencing system over the internet to anyone seeking advice about mental health from a psychiatrist.

### Good governance

- The provider had some systems for monitoring and improving the service but these were not fully developed. The provider completed appropriate audits, monitored incidents and complaints and acted on the learning and outcomes to improve the service. This included an audit of pre-employment checks that showed the provider needed to make some improvements. For example, the provider needed to develop a method of ensuring psychiatrists were checked regularly against the Disclosures and Barring service and General Medical Council. The provider reviewed and recorded mandatory training and appraisals. However, staff who had their appraisals through their NHS job did not have an opportunity to discuss their needs and development in relation to their work with Psychiatry-UK. The provider did not have a supervision policy or arrangements and there were no performance management policies or procedures. This meant there were limited ways to monitor psychiatrists' work, answer questions and provide support. The provider voice-recorded consultations when patients consented. This gave them a means of monitoring psychiatrists' work and they gave an example of listening to a consultation when a concern had been raised by a patient. However, they did not routinely review psychiatrists work using this method.
- There was a lack of safeguarding leadership and oversight. The provider was not aware that staff did not all know how to make a safeguarding alert and had not been sufficiently trained. The provider did not have a system for confirming the identity of the person they were consulting with and this presented a risk staff would not be able to make accurate safeguarding alerts about adults or children. The provider could not assure itself that information they shared was accurate.
- Clinical management of the service was stretched but this was being addressed by the provider. The service was growing and there were plans to appoint a deputy clinical manager. The service was dependent on the registered manager/medical lead and chief operating officer for its governance and leadership."
- There were limited performance indicators. They expected psychiatrists to complete letters following consultations within a week and this was overseen by the administrative team. The provider used feedback from patients as indicators to gauge the performance of the staff team.
- The provider had a risk register that needed developing. The risk register lacked active mitigation to prevent or reduce risks.

### Leadership, morale and staff engagement

- The provider offered staff opportunities to feed back about the service. For example, the provider completed an anonymous survey of 19 staff in August 2017. The survey asked psychiatrists for their attitudes towards remote consultation. In addition the provider had questioned 13 staff and asked them for their feedback. Three staff said they had read the consultation manual, three had not read it and the remainder had not read it in detail. Following the audit, the provider had one-to-one conversations with staff, reminded staff about the manual in newsletters and discussed the audit at their annual general meeting.

Requires improvement

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

- The provider had a fit and proper persons policy. The six psychiatrists on the management board completed an annual declaration about their continued fitness for the role.
- The provider did not monitor sickness or absence. They had not yet developed cover arrangements for staff.
- Staff were aware of the whistle-blowing policy. The policy explained how staff could whistle blow but it did not include information about the sorts of concerns staff could raise, protection they offered to employees or the procedure for handling and investigating concerns raised.
- The leadership team was 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.

**Commitment to quality improvement and innovation**

- The provider was undertaking cyber essential accreditation and adopting national standards as a means of ensuring they had a robust approach to keeping sensitive information secure.
- The provider was collaborating with several organisations to develop new treatments. This included collaboration with an organisation on a treatment for treatment-resistant depression using artificial intelligence and genetic analysis to triage patients. They were also working with a company who provide repetitive transcranial magnetic stimulation to provide assessments for patients to see if the treatment would be suitable for them.
- The provider was working with a GP practice to provider free consultations to its patients.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider MUST take to improve

- The provider must ensure care and treatment is provided in a safe way to patients. It must put measures in place to confirm the identity of the patient before commencing each consultation. The provider must 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 must ensure their safeguarding policies and procedures are clear and detailed and that staff know how to make a referral to the local authority without delay. Arrangements must be in place that staff are familiar with, at all times when they need advice about safeguarding matters. The provider must ensure staff are trained to an appropriate level in safeguarding adults and children. The provider must assure itself that information it passes on to other agencies about risk is accurate and pertaining to the correct person.
- The provider must have sufficient, established and effective systems and processes in place to assess, monitor and improve the quality and safety of the service. The provider must ensure there is oversight and monitoring of psychiatrists' and provide staff with regular supervision. The provider must have a policy and procedure for performance management so it can identify when quality or safety are compromised and address this without delay. The provider must act on feedback it receives from staff.
- The provider must ensure there is an appropriate, formal induction procedure for new staff and that the development of new staff is overseen. The provider must offer support to staff including inviting them to regular team meetings, providing regular supervision and appraisal specific to their work with Psychiatry-UK for staff regularly working for Psychiatry-UK.

### Action the provider SHOULD take to improve

**Action the provider SHOULD take to improve**

- The provider should continue to address the findings of their audit that found risk assessments were not always fully included in letters sent to patients' GPs. The provider should ensure risk is fully documented in all letters and care records.
- The provider should establish a way of ensuring confidential patient information is only stored on their clinical system and not stored on individual's information technology systems where they are unable to oversee the security of the information.
- The provider should ensure all staff are up to date in training about the Mental Capacity Act. They should record whether or not each patient, including children, have consented to treatment and whether or not the patient's capacity to consent to treatment required assessment and the outcome of that assessment.
- The provider should ensure staff are clear about the service criteria, including the age limits for the service.
- The provider should review and develop its whistle-blowing policy and procedure to ensure staff know about the concerns they could raise, how they are protected and the procedure for handling and investigating concerns raised.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>How the regulation was not being met:<br><br>The provider's medicines management framework did not include measures staff should take to confirm the identity of the person they were consulting with. The provider did not confirm the identity of patients at the start of each consultation. There was a risk staff could prescribe for, record and share inaccurate information with other healthcare professionals about the wrong person.<br><br>The provider did not have an embedded system, process or standard operating procedures to protect against patients using of multiple identities.<br><br>This was a breach of regulation 12 (2)(g) |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>How the regulation was not being met:<br><br>The provider did not have robust systems and processes in place to make sure vulnerable people were protected. There was a lack of overall responsibility and training to ensure staff knew when and how to act to protect individuals from abuse. Staff were not sufficiently trained in safeguarding adults and children.<br><br>This was a breach of Regulation 13(1), (2), (3) |

This section is primarily information for the provider

# Requirement notices

| Regulated activity | Regulation |
| --- | --- |
| Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>How the regulation was not being met:<br><br>There was a lack of oversight of the competence of staff, quality of the service and appraisal of the work psychiatrists were providing for Psychiatry-UK. Psychiatrists were not formally supervised and there was a lack of a robust, formal induction programme to ensure staff were sufficiently prepared for their role. Current NHS staff who regularly worked for Psychiatry-UK did not have appraisals specific to their work with Psychiatry-UK.<br><br>This was a breach of regulation 18 (2)(a) |

| Regulated activity | Regulation |
| --- | --- |
| Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>How the regulation was not being met:<br><br>The provider did not have sufficient established systems and processes in place to assess, monitor and improve the quality of and safety of the service. There were no performance indicators or policies or procedures to monitor or manage staff performance. Risks on the provider's risk register had not been mitigated or assessed to enable the provider to prevent or reduce risks.<br><br>This was breach of regulation 17, (2)(a),(f) |

This section is primarily information for the provider

# Enforcement actions

## Action we have told the provider to take

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