

Psychiatric And Psychological Consultant Services Limited

Quality Report

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

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.

Overall summary

We found the following areas of good practice:

- The provider had a separate continuity fund in place to support patients in exceptional circumstances who were unable to pay for further treatment.
- Patients were extremely positive about their experience at the service and felt that staff were professional.
- The service employed a skilled group of specialist clinicians who were able to meet the needs of patients.
- Staff comprehensively assessed patients' needs and ensured that the most appropriate treatment was recommended.
- There was an appointed safeguarding lead for staff to contact if they had concerns.
- The service held regular continuing professional development (CPD) events for all staff to attend. Clinicians and external speakers discussed a relevant subject or a case study.

Summary of findings

- The service was flexible in its approach to appointments. Staff ensured that they were able to offer patients an initial appointment within 48 hours and on a Saturday.
- Staff enjoyed working at the service and the morale was good. The practice manager had worked at the service for over 30 years.
- Patients who used a wheelchair were able to easily access the building and consultation rooms on the ground floor.
- A member of staff was appointed as the safeguarding lead. Staff understood how to report concerns.

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

- Staff did not always complete comprehensive risk assessments, risk management plans and crisis plans for those patients who were deemed to be at risk.
- The service did not have systems in place to safely manage controlled drug prescriptions. The service had not identified a safe place to store controlled drug prescription pads and had not recorded prescription numbers that had been given to patients.
- Staff did not take the appropriate steps to follow up on patients who were at risk and did not attend an appointment or disengaged from the service.
- The service did not have an effective incident reporting system in place. Incidents were not formally recorded and there was no incident reporting protocol in place.
- The service did not have an effective recording system in place to demonstrate that doctors received an appraisal from another place of work in the past 12 months. The service did not have a system in place to record staff training.
- The provider had carried out a health and safety assessment in May 2017. The assessment identified areas of the environment that needed to be addressed without delay such as fire exit signage.
- Clinical equipment such as the weighing scales had not been regularly serviced to ensure they were working correctly.

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		This service was not rated.

Summary of findings

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Psychiatric and Psychological Consultant Services Limited

Services we looked at community-based mental health services for adults of working age

Summary of this inspection

Background to Psychiatric And Psychological Consultant Services Limited

Psychiatric and Psychological Consultant Services Limited is a community-based service that delivers assessment and treatment to adults and young people suffering from psychiatric and psychological difficulties. The main treatment the service offers are psychological therapies such as psychotherapy and cognitive behavioural therapy. However, the service does prescribe some medicines.

The service is registered by the CQC to provide treatment of disease, disorder or injury. During our inspection, we reviewed how the service was meeting the regulated activity. We assessed how medicines were prescribed and whether clients received a review by a doctor.

The service accepts referrals from medical insurers, returning patients, individual GPs and psychiatrists. At the time of the inspection, the service had an overall caseload of 600 people.

The service has a registered manager in place and was in the process of changing the nominated individual role to a senior manager. A nominated individual is a senior member of staff who has overall responsibility for the service. The service has been registered with the Care Quality Commission (CQC) since 2011. We last inspected the service in 2013 and they were found to have met the essential standards. The inspection covered in this report was against the new regulations called fundamental standards. The inspection team visited the service on 30 and 31 May 2017.

Our inspection team

The team that inspected the service comprised of two CQC inspectors, one inspection manager, and a specialist advisor who had a working background in clinical psychology.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme to make sure health and care services in England meet the Health and Social Care Act 2008 (regulated activities) regulations 2014.

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 and the information the provider had sent to us.

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 three patients who were using the service

Summary of this inspection

- spoke with the registered manager and five senior managers for the service
- spoke with a doctor and a psychologist
- collected feedback from 15 patients using comment cards
- looked at 19 care and treatment records of patients
- carried out a specific check of the medication management
- 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 received feedback from patients and comment cards. Overall, patients said they had received a good service

and were positive about their experience. Patients felt that staff were polite and professional. Patients told us that they felt they were understood and that the service was flexible in their approach to appointment times.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found the following issues that the service provider needs to improve:

- Whilst most staff assessed risk appropriately, staff did not always complete comprehensive risk assessments, risk management plans and crisis plans for those patients who were at risk.
- Staff did not always ensure that they followed up on patients who were at risk and did not attend an appointment or disengaged with the service.
- Medicines were not managed safely. The service had not ensured that there was a system in place to safely store controlled drug prescription pads and record the prescription numbers that had been given to patients.
- The service did not have a clear incident reporting system in place. Incidents were not formally logged and there was no incident reporting policy to guide staff.
- The service did not have a clear system in place to effectively monitor staff training.

However, we also found the following areas of good practice:

- The service had a safeguarding lead in place and staff understood how to raise concerns.
- The service employed a wide range of specialist clinicians to ensure that patients would receive the necessary treatment and support.
- Staff nominated each other to cover caseloads whilst they were on leave or off sick. This ensured that patients always had continuous support.

Are services effective?

We found the following areas of good practice:

- Patients received a comprehensive initial assessment with the recommended treatment documented in their care records.
- In the records we reviewed, psychiatrists prescribed safe dosages of medicines that were within British National Formulary limits.
- Staff carried out a comprehensive annual care record audit to assess and monitor the quality of the clinical notes.
- The service facilitated regular continuing professional development (CPD) events where a clinician or an external speaker would present a subject.

Summary of this inspection

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

- The service did not have an effective system in place to record that staff had received an appraisal in the past 12 months.

Are services caring?

We found the following areas of good practice:

- The feedback we received from patients was extremely positive. Patients felt that staff understood them and met their needs.
- A patient representative was involved in the board meetings. This ensured that a patient who had experienced the service was involved in the decision-making process.
- The service had a separate continuity fund in place to cover treatment fees for patients who no longer could afford treatment. This ensured that patients would still be supported with their recovery.

Are services responsive?

We found the following areas of good practice:

- The layout of the building meant that people who used a wheelchair could access the service.
- The service ensured that they were flexible in their approach to appointments. Patients were offered an initial appointment within 48 hours and appointments were available on a Saturday.
- The service handled and managed complaints appropriately.

Are services well-led?

We found the following areas of good practice:

- The chair had a clear vision for the service. This included offering different psychological based therapies and improving the joint working between staff.
- The service had an established board of directors and a separate clinical advisory board who regularly reviewed the service.
- Overall, morale was good and staff enjoyed working at the service. Some staff had worked at the service for many years.
- The service had a risk register and business interruption plan in place.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Patients voluntarily approached the service for treatment and they were presumed to have the capacity to consent. In all treatment records we inspected, we saw that all clients had consented to treatment.

Community-based mental health services for adults of working age

Safe

Effective

Caring

Responsive

Well-led

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

Safe and clean environment

- The service completed an annual health and safety assessment in May 2017, which identified several areas for improvement. Issues included that staff had not been fire trained, there was no assessment of the premises showing how the risk of fire would be mitigated and the fire exit and directional signs were out-of-date. The provider was in the process of developing an action plan to ensure they addressed these concerns.
- The service had a working lift that was inspected on a monthly basis by an external company.
- Domestic staff followed a cleaning schedule. The environment was clean and tidy.
- The service did not have a clinical room because clinical procedures were not carried out on site. However, some consultation rooms had weighing scales that were regularly used but had not been serviced within the last 12 months. The service could not be assured that the scales were working correctly.

Safe staffing

- The service employed a full-time practice manager and an accounts manager. Other members of the team included a range of part-time managers including the chairperson (who was also the owner of the service), chief executive, medical director, director of psychology and commercial director. In total, 17 psychiatrists and 16 psychologists worked at the service on a sessional basis. Doctors worked at the service as part of their practising privileges. This meant that the individual doctors had been granted permission by another organisation to practice privately. Some staff worked at other providers including the NHS.

- The service ensured that there were cover arrangements in place for when staff were on leave or off sick. Clinicians nominated another clinician to cover their caseload.
- The service completed detailed recruitment checks for all staff. We reviewed four employment records and found that all staff had provided appropriate references and had undergone disclosure and barring (DBS) checks.
- The provider did not keep adequate records of staff training. Although we saw evidence that training had been offered to staff, individual staff records did not clearly demonstrate which members of staff had completed training. The service did not have an effective training log in place that showed completion rates. The service did not have a training policy that outlined which training courses staff needed to complete in order to safely perform their role. The service could not demonstrate effectively that staff were appropriately trained to carry out their role.

Assessing and managing risk to patients and staff

- Staff carried out initial risk assessments for most patients. We found that staff had completed a full risk assessment for 13 out of 19 patients whose records we inspected. However, five records were either incomplete or lacked sufficient information to demonstrate that risk had been explored in detail. They were either incomplete or lacked sufficient detail. In one treatment record, a risk assessment had not been carried out. This was raised to the chief executive, who acknowledged the issue and agreed to follow up.
- Whilst the service mostly saw low risk patients, staff did not routinely complete risk management plans for high risk patients. We reviewed a treatment record of one patient who had depression and expressed suicidal thoughts. Staff did not complete joint crisis and risk management plans that were agreed with the patient.

Community-based mental health services for adults of working age

Without these plans in place, there was an increased risk that the patient would not be supported by the service. The service carried out an annual care record audit. The most recent audit had identified the same concerns that we found during the inspection. As a result, the service had implemented a treatment record 'dataset', which was a set of prompts to guide staff when recording information.

- Staff did not always ensure that they followed up on patients where potential risks had been identified who did not attend or had disengaged with the service. We found in two separate records that the patients had suddenly stopped attending appointments. The treatment records did not demonstrate how staff responded. Staff could not be assured that the patients were safe and were able to access support in the community.
- The management of controlled drug prescriptions (CD) did not adhere to national guidance. One doctor was authorised to have access to blank CD prescription pads. However, we found that all staff had access to prescriptions. There was a risk that prescription pads could be misused. Staff did not record CD prescription numbers that had been received or used. The provider's policy for the prescribing of CDs had not been reviewed since 2013. The policy did not include the names of the current staff who were authorised to prescribe CDs. Following the inspection, the practice manager had located a locked cabinet for the prescription pads to be stored in.
- The service had a policy in place for safeguarding adults and children at risk. A psychiatrist was the safeguarding lead for the service. In all consultation rooms, contact details for the local safeguarding teams were displayed. Staff we spoke with understood how to raise concerns with the safeguarding lead and had access to the contact details to formally raise a concern to the local authority. The service had not received any safeguarding alerts that they needed to report within the past 12 months.

Track record on safety

- The service had no serious incidents in the past 12 months. The last serious incident was in 2015. The service carried out a full investigation and found that staff had acted appropriately.

Reporting incidents and learning from when things go wrong

- The service did not have an effective incident reporting procedure in place to ensure that all incidents were reported and reviewed. Whilst the practice manager kept an accident reporting book for minor incidents such as slips, trips and falls, there was no incident reporting log for the patients. Incidents were not routinely logged and there was no summary of the incidents that had occurred in the past. The lack of guidance increased the risk of staff not reporting incidents. Staff we spoke with did not understand the types of incidents that would need reporting but told us that major incidents such as a patient death would be reported to the clinical advisory board for investigation. During the inspection, the provider had started to write an incident reporting policy.
- The service did not have a clear communication system in place to share incident related information. Staff we spoke with were not aware of the patient related incident that happened in 2015. The lack of communication increased the risk that staff who worked part-time would not be aware of incidents and any changes in practice as a result.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. The service did not have a policy that outlined duty of candour principles. However, staff were able to provide us with an example of where a treatment record had been lost and then found. Staff were open and informed the patient straightaway. Staff had not yet received training on the duty of candour but this was planned for 2017.

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

(for example, treatment is effective)

Assessment of needs and planning of care

- Staff assessed patients' needs during the initial appointment. We reviewed 19 treatment records and

Community-based mental health services for adults of working age

found that staff had carried out an initial assessment. Staff completed treatment plans, which outlined the treatment recommended. Treatment was reviewed regularly and patients were discharged back to the referrer once completed.

- Arrangements were in place for the secure storage of confidential records.

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 medicine records and found that prescribing was within recommended dose limits and staff communicated regularly with patients' individual GPs.
- Staff provided NICE recommended therapies. Staff used cognitive behavioural therapy and psychotherapy to support patients. The service had plans to expand the types of therapies offered to patients.
- Staff carried out some physical health checks on patients such as height and weight. These checks were only for people who were prescribed medicines. We reviewed four treatment records for patients who had been prescribed medicines. The records included each patient's past medical and medication history.
- The service had started to use Health of the Nation Outcomes Scales (HoNOS) as a way of showing how effective treatment was. The scale is used to measure the health and social functioning of people with severe mental illness. Staff received training by an NHS provider on how to complete HoNOS. Senior managers told us that not all staff consistently completed the scale and the service was trying to improve this.
- Senior staff carried out an annual clinical record audit that looked at the quality of individual staff members' treatment records. The audit found that some staff were not assessing risk appropriately and record keeping required further improvements.

Skilled staff to deliver care

- The service employed psychiatrists and psychologists to carry out assessments and deliver treatment.
- The service had a statement of purpose protocol in place that showed what new staff members could expect in their induction. New staff confirmed that they had completed an induction.

- Whilst psychiatrists received annual appraisals, the service did not always ensure that they kept adequate records of the appraisal. In eight out of the 10 employment records reviewed, the records did not demonstrate that the doctors had received an appraisal by another place of work in the past 12 months. This meant that the service could not be assured that the doctors received a review of their clinical practice. The service had recognised that this was an issue and had plans to create a database that would alert the human resources team when a staff appraisal was due.
- The practice manager was part of the practice management forum and mentored managers in other services. This enabled the manager to learn from other providers.
- The service ensured that new psychologists were supported by offering them three peer meetings with a senior psychologist. We saw records of individual staff meetings that showed staff discussing individual cases, and operational issues such as good record keeping.
- The service provided continuing professional development sessions throughout the year. Clinicians and outside speakers presented on a topic such as a research project. Staff from the service attended, and clinicians from other providers were able to attend for a fee.
- The service did not offer other specialist training because most staff also worked in the NHS and were able to transfer their training into the service. The service did not keep a full record of the training staff had received. This meant they could not be sure all staff were appropriately trained for their role.

Multi-disciplinary and inter-agency team work

- The service did not have team meetings because the clinicians did not work full-time at the service. Managers communicated with staff via email.
- Patients gave the details of their GP when they joined the service and had the option to withhold the information. Most staff ensured that they communicated with patients' individual GPs and had a good working relationship with a local hospital for patients that required inpatient treatment. We saw evidence of one patient who was referred to an inpatient service.

Good practice in applying the MCA

Community-based mental health services for adults of working age

- Patients voluntarily approached the service for treatment and they were presumed to have the capacity to consent. We reviewed 19 treatment records and found that all patients had given consent prior to treatment commencing.

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

Kindness, dignity, respect and support

- During the inspection, we observed staff being caring and welcoming towards patients.
- The feedback we received from three patients and 15 comment cards was positive. Patients felt that they were listened to and staff were helpful. We heard comments such as, “the service has been excellent” and “staff are professional.”
- The clinical advisory board (CAB) had a separate continuity fund in place to support fees for patients who were no longer able to afford treatment. Staff were able to take exceptional cases to the clinical advisory board (CAB) and request to use the fund. This ensured that patients who were unwell would still receive support.

The involvement of people in the care they receive

- Patients told us that they felt involved in their care and staff treated their needs as a priority.
- Patients were able to feedback via the ‘customer satisfaction questionnaire’ at the point of discharge. In the past 12 months, the service had received 26 completed questionnaires. Feedback was positive, showing that most patients were satisfied with their experience. A patient representative sat on the board and attended the quarterly meetings.

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

Access and discharge

- The service monitored each patient’s referral pathway into the service. During 2015 to 2016 the service had received 521 referrals. Twenty-five percent of referrals

came from GPs and psychiatrists, 25% from other providers, 25% were people returning, and the other 25% were referrals from corporate companies and medical insurers.

- The service did not have a waiting list and staff ensured that patients were able to access an appointment within 48 hours. We saw evidence in the screening and referral log that patients were assessed quickly. All patients told us that the service was flexible and appointments were always available.
- The provider was in the process of developing a discharge policy for staff to use.

The facilities promote recovery, comfort, dignity and confidentiality

- The service offered a range of consultation rooms to support treatment. However, the ground floor consultation room that was located behind the waiting room was not adequately sound proofed. During the inspection, we found that some conversations could be heard from the waiting area.
- Patients had access to leaflets about the service that included how to complain and opening times.

Meeting the needs of all people who use the service

- The building was equipped to provide assisted wheelchair access. Staff could place a ramp at the entrance door and clients could be seen in the ground floor consultation rooms. During the inspection, we observed that this worked well.
- The service was open on a Saturday to meet the needs of patients who worked during the week. The service had a system in place for when clinicians were on annual leave. Staff nominated another relevant clinician to cover their caseload.
- Staff were able to access external interpreters if required. The provider told us that this had not yet been necessary.

Listening to and learning from concerns and complaints

- The service had a complaints policy in place and patients had access to information about the complaints process. However, the information on the leaflet was not accurate because it stated that if the complaint could not be resolved it may be raised with

Community-based mental health services for adults of working age

the Care Quality Commission (CQC). This could imply that the CQC would investigate the complaint. During the inspection, we raised this with the provider and outlined our role in public complaints. The provider told us that the wording would be changed.

- The service ensured complaints were appropriately managed. In the past 12 months, the provider had received one complaint. The service had kept a clear log of the complaint, correspondence between the patient and the final response. The complaint was regularly discussed at the clinical advisory board meetings (CAB) to ensure staff were updated.
- Patients we spoke with understood how to make a complaint and raise any concerns.

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

Vision and values

- Staff understood that the aim of the service was to provide a quality service that was responsive to people's needs. Senior staff recognised that there were areas for improvement such as record keeping.
- The chairperson had a clear vision for the future of the service. The chair aspired to increase the range of psychological based therapies offered to patients and aimed to improve the joint working of the multi-disciplinary team.

Good governance

- The service had a governance structure in place. This included the clinical advisory board (CAB) which

consisted of a group of clinical staff who reviewed practice and made recommendations directly to the board of directors. The CAB met every three months. The board of directors acted as an ethics and audit committee and signed off policies and procedures. The board met on a monthly basis.

- Whilst the provider had recognised that some areas of practice needed improving, there were other aspects of the service that the provider's governance system had not identified as a concern. For example, the service did not have a system in place for managing prescriptions safely. There was no clear system in place to record staff training and appraisals. The service did not have a system in place to report and manage incidents. Following the inspection, the service sent us an action plan demonstrating how the concerns would be addressed.
- The service had a combined service risk register and a business interruption plan. The register outlined the risks to the business such as losing key members of staff, loss of IT and problems with the premises. Each risk was prioritised and it was documented whether each risk was insured against.

Leadership, morale and staff engagement

- Overall, the morale was good and staff enjoyed working at the service. Managers and some clinicians had worked at the service for a substantial amount of time, ranging between six and 35 years. Staff felt that the service was professional and the provider looked after staff and the patients.
- Staff understood how to raise concerns within the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure that there are systems in place to manage controlled drug prescriptions safely. This includes ensuring prescriptions pads are safely stored and prescription records are accurately maintained.
- The provider must ensure that staff assess and clearly record risk assessments, risk management plans and crisis plans for those patients who are at risk.
- The provider must ensure that staff follow up all clients who are at risk and do not attend appointments. This includes recording the action taken.

- The provider must ensure that there is a clear incident reporting system and policy in place.
- The provider must ensure that there are appropriate systems in place that monitors staff training and ensures staff have been appraised in the past 12 months.

Action the provider **SHOULD** take to improve

- The provider should ensure that the service addresses the health and safety concerns that were raised in the provider's recent assessment.
- The provider should ensure that clinical equipment, including weighing scales, is regularly serviced to ensure it is working correctly.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>The management of controlled drug prescriptions were not handled safely.</p> <p>Patients' risks was not always appropriately assessed and recorded. A risk management plan and crisis plan had not been put in place for one patient who was at risk.</p> <p>The provider did not have an incident reporting system or policy in place. The service did not record incidents.</p> <p>Staff did not follow up on patients who were at risk and did not attend appointments or disengaged with the service.</p> <p>This was breach of regulation 12(1)(2)(a)(b)(g)(i).</p>
Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p>The provider did not have systems in place that effectively monitored staff training and ensured that staff received an annual appraisal by their place of work.</p> <p>This was a breach of regulation 18(1)(2)(a)</p>