LANCuk Heywood

Quality Report

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

Ratings

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

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 Learning Assessment and Neurocare Centre Limited as inadequate because:

- There was no training that was determined mandatory for staff in order for them to have the skills they needed for their job roles. There were no records of training for sessional staff available.
- Safeguarding training was not completed for staff and the policy gave limited direction to support staff. There was no system for staff to alert others if there was an incident whilst seeing a patient alone.
- The duty of candour policy did not identify what level of harm would need a duty of candour response.
- We were not assured the provider had good oversight of risks of people waiting to be seen because contact from patients were not recorded.
- Staff were not receiving supervision or appraisal.
- Patient records were not contemporaneous and incomplete.
- There were limited records that appropriate checks on staff suitability had been carried out.
- All patients we spoke to told us they were not given information on how to complain.
- We did not find sufficient arrangements in place for the provider to determine the quality of the service provided and make improvements.
- Staff had not received appropriate checks prior to commencing their role. The provider could not evidence that appropriate checks had been carried out prior to staff commencing in their role. In ten staff files we reviewed there were no application forms, curriculum vitae, references or DBS checks. In addition, there was no evidence of staff training either at LANCuk Ltd or at sessional workers permanent roles.

However:

- The premises were visibly clean, tidy and were suitable for patients.
- Staff at the service had reported no serious incidents in the twelve months leading up to our inspection. However, it was difficult to know if there had been any due to the lack of documentation at the service. We did not find any evidence on the day of our inspection that any serious incidents had occurred.
- All records we reviewed contained a full assessment.
- The service liaised well with others such as GPs. were good examples of shared care agreement with patients GPs.
- The provider followed national institute of health and care excellence guidance for assessment, diagnosis and prescribing of medication.
- There was an effective multidisciplinary team approach.
- Staff told us they were supported and could approach colleagues for advice with complex cases.
- All patients we spoke to told us that staff treated them with dignity and respect. Carers we spoke to told us that staff involved them in decisions about their loved ones care and

  felt they genuinely took an interest in their problems. Patients told us they were consulted about their treatment options and given information to help them make an informed decision. The rooms that were used for patient appointments were adequately soundproofed for confidentiality. Information about advocacy services were displayed for patient to use. Patients could give feedback via surveys and comment boxes.
- The provider was meeting targets for referral to assessment time. Patients were able to access staff quickly via telephone or email. There was a full range of rooms to provide treatment and care. The premises were accessible for people requiring disabled access via a ramp. Interpreters were available for patients whose first language was not English.

Summary of findings

- Staff morale was high and staff felt empowered in their roles. There was an open and honest culture at the service.

Summary of findings

Contents

Inadequate

LANCuk Heywood

Services we looked at;
Outpatient services (for people of all ages)

Summary of this inspection

Background to LANCuk Heywood

Learning Assessment and Neurocare Centre Limited has been registered with the Care Quality Commission since 19 October 2017. It is an assessment and diagnostic service for people who have symptoms of autistic spectrum disorder or attention deficit hyperactivity disorder.

The centre sees patients of all ages from the private sector and they also have a commissioned contract with the NHS for assessments and diagnostics in the Bury, Rochdale and Oldham area of Manchester for adults (16 plus in Oldham and 18 plus in Bury and Rochdale).

There is office space in Cheshire and London for appointments and the provider has one registered location registered as LANCuk Heywood where the main administration office of the provider is based. LANCuk Heywood has been registered with CQC since 19 October 2017.

Learning Assessment and Neurocare Limited is registered to carry out the following regulated activities:

- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

There have been no previous inspections of this location. There was a registered manager in post at the time of our inspection, this person was also the company director.

Our inspection team

The team that inspected the service comprised two CQC inspectors and specialist advisor who was a nurse specialist in autism and attention deficit hyperactivity disorder.

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 and asked the people who commissioned the NHS contract for information about the service.

During the inspection visit, the inspection team:

- visited the location and looked at quality of the environment and observed how staff were caring for patients
- spoke with six patients who were using the service and four carers
- spoke with the registered manager
- spoke with five other staff members; including doctors, nurses, life coach and administration staff
- observed one life coaching session with a patient
- received feedback about the service from three commissioners

Summary of this inspection

- looked at eight care and treatment records of patients
- carried out a specific check of the medication management arrangements at the location
- looked at ten staff files
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients we spoke to told us that staff were kind, caring and genuinely interested in their wellbeing. They felt included in decisions about their care and were given information about treatments and their options before being started on any medication.

Patients who attended the life coaching told us that they felt supported in achieving goals they had set with a clear plan of how to do this.

Carers told us that when the patient wanted them to be they were fully involved in their loved ones' care. They were given relevant information and involved in the assessment process providing important information such as childhood milestones and behaviour in early years.

Although patients we spoke to told us they had not been given the complaints procedure on admission, they did feel confident that they could raise issues with the provider and be listened to.

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?

Inadequate

We rated safe as inadequate because:

- Staff did not have access to a programme of mandatory training. Sessional staff did not provide evidence of ongoing training in their permanent role.
- Staff did not have access to an alarm system when they saw patients alone. Staff had not received safeguarding training. The provider's safeguarding policy was not clear on how staff should report safeguarding concerns.
- The duty of candour policy did not identify what level of harm would need a duty of candour response.
- The provider did not effectively monitor the risks of people waiting to be seen. Telephone calls and emails from patients were not recorded on the patient record system.

However,

- Rooms at the service were clean tidy and well maintained. They were decorated in calming colours and provided a low stimulus environment.
- There had been no serious incidents at the service in the twelve months leading up to our inspection.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Records showed staff had not received supervision or appraisal to make sure they had the correct skills to support patients in the last 12 months.
- Patient records were not complete. There were no contemporaneous records kept of patient contact daily.
- Staff assessed physical health of patients prior to commencing medication but did not follow up on identified issues and concerns.
- There was no specialist training available for staff.
- The mental capacity policy (consent policy) was not relevant to LANCuk. The policy made reference to "the trust" throughout and referred to procedures and activities which were not offered by LANCuk.

However,

- All records we reviewed contained a full and timely assessment.
- There were good examples of shared care agreement with GPs for patients on medication.

Summary of this inspection

- Records were secure and password protected.
- The provider followed national institute of health and care excellence guidance for assessment, diagnosis and prescribing medication
- The provider had developed a life coaching course whereby patients could make their own goals that they would like to achieve with support from the life coach.
- Staff supported patients with applications for benefits.
- There was a good multidisciplinary team including doctors, nurses, occupational therapist and speech and language therapists.
- Staff told us they felt supported and could approach colleagues for advice with complex cases.

Are services caring?

Good

We rated caring as good because:

- All patients we spoke to told us that staff treated them with dignity and respect.
- Carers we spoke to told us that staff involved them in decisions about their loved ones' care and felt they genuinely took an interest in their problems.
- Patients told us they were consulted about their treatment options and given information to help them make an informed decision.
- Consultation rooms were adequately soundproofed for confidentiality.
- Information about advocacy services were displayed for patient to use.
- Patients could give feedback via surveys and comment boxes.

However,

- All patients we spoke to told us they were not given information on how to complain when they entered the service.

Are services responsive?

Good

We rated responsive as good because:

- The provider was meeting targets for referral to assessment time.
- Patients could access staff quickly via telephone or email.
- There was a full range of rooms to provide treatment and care.
- The premises were accessible for people requiring disabled access via a ramp.
- Interpreters were available for patients whose first language was not English.

However,

Summary of this inspection

- The complaints policy provided incorrect guidance to people who were unhappy with the outcome of a complaint.
- There was no process in place should a complaint be made about the registered manager who was the only director.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- We did not find governance structures in place for the manager to evidence they had good oversight of; staff training, staff background checks on commencement of employment, ongoing evidence of staff training, supervision and appraisal of staff to monitor performance, a policy to monitor poor performance, record keeping including recording of complaints, concerns and queries or a robust safeguarding policy.
- Staff had not received appropriate checks prior to commencing their role. The provider could not evidence that appropriate checks had been carried out prior to staff commencing in their role. In ten staff files we reviewed there were no application forms, curriculum vitae, references or DBS checks. In addition, there was no evidence of staff training either at LANCuk Ltd or at sessional workers permanent roles.
- The registered manager was asked to complete safeguarding training as part of the registration process.The manager did not do this; despite the safeguarding policy directing all staff to the registered manager if a safeguarding issue was raised.
- The risk register did not state when issues would be reviewed or completed by, neither did it show how actions were going to be completed.

However,

- Staff morale at the service was high with staff feeling empowered in their roles
- There was an open and honest culture.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had a good understanding of the Mental Capacity Act relevant to their role. They could tell us the main principles and how they would assess this when meeting with patients to be sure they were able to give informed consent.

There was no policy around the Mental Capacity Act 2005 although there was a policy titled consent. However, this policy did appear to have been copied and pasted from elsewhere as the policy refers to "the trust" throughout which would indicate that of a policy for an NHS hospital trust. The policy also talks about eLearning modules and mental capacity act training available at "the trust" which was not something LANCuk provided. There was also a section about clinical photography and conventional of digital video recordings which would not be relevant to LANCuk.

There was no monitoring of when clinicians had last received updates in the Mental Capacity Act 2005 (MCA 2005) or the Gillick Competency / Fraser Guidelines (guidance in obtaining consent from patients under 16) and training was not provided by LANCuk for permanent staff.

Inadequate

Outpatient services (for people of all ages)

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

Are outpatient services (for people of all ages) safe?

Inadequate

Safe and clean environment

The building was clean, tidy and well maintained. Rooms were decorated in neutral colours and were kept as low stimulus as possible. Interview rooms were not fitted with nurse call alarms. This meant staff could not call for help if it was required. However, when appointments were ongoing staff made a point of walking up and down the corridors periodically to check on colleagues. There had been no incidents in the twelve months leading up to our inspection of this nature.

The service did not have a dedicated clinic room. However, staff had access to equipment for weighing and measuring patients who were on medication. Patients' height and weight were key determinants' in identifying the appropriate level of medication.

There was a cleaner employed by the building who maintained the cleanliness of the offices used by patients. Cleaning records were kept up to date by this person.

Safe staffing

The clinic employed two permanent members of staff plus the registered manager. The rest of the staff were self-employed sessional workers who were subcontracted to undertake assessments. There were twenty sessional workers who were used on an ad hoc basis by the centre. There were two members of staff who although were self-employed worked full time at the centre and were the lead for the two care pathways at the centre (ASD and ADHD). Therefore, clinicians did not carry a caseload as such but would work with patients on a short-term basis to carry out an assessment and diagnostic screening, this would usually consist of around three appointments one for assessment, one for feedback and one for a post diagnostic follow up appointment.

Staff we spoke with told us there was no programme of mandatory training. This was confirmed by the manager. This meant that for the two permanent members of staff and the registered manager there was no training. For sessional workers the registered manager sent out an email once a year asking them to provide evidence of mandatory training in their permanent role. However, when we reviewed staff files we found no evidence of this in the ten files we sampled.

Assessing and managing risk to patients and staff

There was not a formal risk assessment tool in place at the centre. However, risks were captured in the referral form used by people wanting to refer patients to the service. This captured risks such as history of self-harm and current thoughts, suicidal intent, history of violence and aggression and risk of self-neglect. At the end of sessions with patients' staff would recap any risks identified and go through plans of what the patient should do in a crisis. Staff told us they would advise patients to contact the crisis team at the local mental health trust or use other crisis numbers for their own local area. As patients referred to the centre are under the care of other agencies for example the mental health team, they would manage the risks of the patient on a more ongoing basis as they had a higher level of involvement with the patient. The centre had also thought

Inadequate

Outpatient services (for people of all ages)

about risk in the building for example, rooms were set up so that staff were nearer to the door during assessments and there was a buzzer system for people coming into the building.

There was no waiting list for appointments. The centre had targets of six weeks for urgent referrals and twelve weeks for non-urgent and was meeting these in 98% of cases. However, staff did not proactively monitor patients waiting for appointments to detect and respond to changed circumstances or levels of risk. Staff did not routinely contact people on the waiting list. When people did contact the centre to enquire about an appointment for example, this was not captured in any records. Administrators mainly dealt with incoming calls and these staff were not trained to deal with a patient in a mental health crisis. Staff told us that if a patient was ringing and they felt the person was becoming agitated or upset then they could add this in a word document to the patients file, however, there was no way of alerting a practitioner that this had been done and therefore we did not feel assured that risks were being monitored and captured in all instances.

Staff had not received training in safeguarding. There was a policy in place that explained the process for recognising and reporting safeguarding referrals. However, we found that the policy had significant gaps. The policy stated all safeguarding referrals should go through the registered manager who would raise them with the relevant local authority. The registered manager informed us during their registration process that they would complete safeguarding training to ensure they were appropriately skilled for this role. The registered manager had not completed this training. In addition, there was no information to guide staff on how to raise a referral if the registered manager was unavailable or if it was out of hours. Staff we spoke with told us that in those circumstances they would search online to identify the relevant local authority and their reporting procedures. However, the record system used by the service did not allow staff to record daily records or log phone calls and actions. This meant that there was no audit trial to evidence that referrals had been made and no record of actions taken.

There was no lone working at the centre, as a minimum two staff would always be in the building if a patient was attending for assessment. When staff were in appointments with patients the administration staff would routinely walk around just to check staff were ok. There was a building manager who oversaw the running of the building. There was CCTV in the reception area and appropriate signage for this was displayed.

Track record on safety

There had been no serious incidents in the centre for the twelve months leading up to our inspection. We saw no incidents when reviewing records and staff or patients did not report any to us. However, as documentation was poor we could not be certain that all incidents were recorded correctly.

Reporting incidents and learning from when things go wrong

There was a policy for reporting incidents at the centre. There had not been any incidents in the twelve months leading up to our inspection. However, staff we spoke to were aware of how to report incidents. There were no incidents to review during the inspection but staff were able to talk us through how learning from incidents would be shared via the monthly multi-disciplinary meeting, the minutes of these were shared with all staff whether in attendance or not.

Staff we interviewed were aware of the duty of candour and the need to be open and honest in the culture of their work. There was a duty of candour policy which outlined what duty of candour is and what staff needed to do if an incident required this type of response for example offer a written apology and a meeting with the patient to explain. However, the policy did not detail what type or level of incident met the criteria for duty of candour. In addition, staff had not received training around duty of candour to support the implementation of the policy. This meant the service did not have a robust framework in place to ensure that incidents that met the duty of candour threshold would be identified and actioned as such.

Are outpatient services (for people of all ages) effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

Inadequate

Outpatient services (for people of all ages)

We reviewed eight patient records during our inspection. All records contained a full assessment of the patient that was completed in a timely manner. This was in the form of a letter that was shared with the patient and their referrer and GP. It contained information provided by the patient at assessment and the professional's impression of the outcome and plan going forward. For patients who were on medication for ADHD that was at a stable effective dose there was a shared care agreement in place with the patients GP. We found these to be of a good standard and contain all relevant information for the management of that patient and their symptoms.

The service was an assessment and diagnosis service so did not develop formal care plans for patients who were not on medication or taking part in life coaching. However, staff did develop plans for patients which included areas such as medication, life coaching sessions or a follow up appointment for post diagnostic support. Patients were also encouraged to contact the centre even after their discharge from the service if they had any questions or concerns going forward and support would be offered over the telephone or via email.

Records were kept on an electronic system. This was accessible via a username and password which was individual to each member of staff.

Best practice in treatment and care

The centre was following national institute for health and care excellence guidance for attention deficit hyperactivity disorder: diagnosis and management [NG87] for the prescribing, titration and monitoring of medication. This meant that medication was prescribed in a safe way and monitoring for side effects and adverse reactions was carried out by a trained professional.

Although the centre was predominantly an assessment and diagnostic service they had developed a life coaching course that patients could access for a six-month period. During this time the patients would work on setting goals in order to achieve things they felt were important to them. This included things such as getting back into work, using public transport, getting involved in voluntary work or a hobby. For people taking part in life coaching there was a plan in place between the life coach and the patient which outlined their goals and how they planned to achieve them. Life coaching could also support access to benefits if this was something the patient wanted support with and other therapists at the centre were also able to support applications for benefits outside of life coaching.

Staff completed physical health checks on patients. For example, prior to commencing a patient on medication checks were carried out on their blood pressure. For children weight and height was also checked. The outcome of these tests were communicated to patients in the clinic letter. However, there was no evidence that staff identified or responded to irregular or concerning results. For example, we found one record where a patient had low blood pressure. The blood pressure was recorded in the clinic letter but no other records were made to detail if this was normal for the patient, if it had been considered further or what the outcome was. We found two other examples where there was an anomaly in physical health assessments but no further explanation to detail the response of staff. We received feedback from the provider following our inspection on how this was managed but this would have been best practice to document in the record at the time of the assessment. However, the records system did allow for this.

Staff used the Barkley adult attention deficit hyperactivity disorder assessment tool to measuring outcomes for adults with attention deficit hyperactivity disorder. This was completed at each appointment with a view to monitoring a decrease in symptoms as medication was increased to the optimum dose. The centre aimed to completely get rid of symptoms for patients when on the correct medication and dose.

We found that there were very few examples of clinical audit at the centre. In the provider information return that was sent to us prior to the inspection a medication record audit had been carried out in December 2017. This was to review whether the centre was effective in providing repeat prescriptions for patients. The audit found that in 96% of 35 cases repeat prescriptions were issued on time. There was another audit which reviewed all clinical letters for evidence of physical health checks where appropriate. This showed that 100% of the time physical health checks were either carried out, or if not possible, requested by the GP, to be completed, before medication was initiated. However,

there was no formal audit programme in place where audits were repeated to check ongoing compliance and the results of these audits were not used to drive any improvement in the service.

We reviewed the provider's policies around completing different audits and found that in parts they were unclear or contradictory. For example, in the policy for monitoring staff performance it stated that all staff reports should be reviewed by the registered manager, but on the next line it stated that a sample of reports should be reviewed by the registered manager. This meant that the consistency and effectiveness of audits could not be assured and that there was potential for any repeat or follow-up audits that did take place to be completed to different standards.

Skilled staff to deliver care

The service employed a range of staff to ensure that they could meet the needs of patients. This included speech and language therapist, occupational therapist, consultant psychiatrists, specialist nurses in autism, a life coach and administration staff. Most staff were employed on a sessional basis. The registered manager was a chartered psychologist.

During our inspection we reviewed 10 out of 20 staff files. We found all but one file contained a print out of the clinician's registration status. For example, if this was a nurse their NMC pin number and the date of renewal and if this was a doctor their GMC registration. Staff files we reviewed did not contain application forms, curriculum vitaes, disclosure and barring service certificates, references or proof of ongoing training in the staff member's permanent role. The registered manager stated that the service took references over the phone. However, those conversations were not recorded and written references were not available. This meant that the service could not evidence to us that staff were of good character or suitably qualified for their role.

Following our inspection, we asked the registered manager to provide immediate assurance that staff working alone with vulnerable adults had a DBS certificate in place otherwise to provide us of evidence that those individuals would not be able to work unsupervised until these checks were in place. This information was received and demonstrated that all staff had been checked using the relevant disclosure and checks.

Staff supervision and appraisal was not taking place effectively. For the two permanent members of staff we found one of their records contained an appraisal, the form was partially completed and the part where the employee fills in their comments and plan for the development of that individual going forward was left blank. The second contained an appraisal not on the form and this was hand written with no date and no date for reviews throughout the year to check on progress. One of the ten sessional workers files contained an appraisal. The appraisal policy stated that appraisals should take place annually with a six-monthly review, there was no form contained within the policy for staff to use. For sessional staff there was no evidence of proof of an appraisal in their full-time job being sent through to LANCuk.

The supervision policy stated that staff should be having one hour per month of supervision. It did not state if this was clinical or managerial and we found no evidence of staff having supervision formally documented in any of the ten files we examined. One file contained an agreement with a clinical supervisor outside of the organisation that the member of staff had arranged for themselves up until the end of 2019. When discussed with the registered manager they described that staff would be paired up with another staff member once per year to observe each other's practice and give feedback. However, the registered manager was unable to provide records of the observation and feedback.

The registered manager described the multi-disciplinary team meeting as a group supervision. However, when we reviewed minutes of these meetings although we found that patients were discussed there was no record of who attended the meetings so therefore it was difficult to see if this was useful as a form of supervision.

Staff did not have access to peer to peer clinical supervision. For example, the life coach did have a life coach to supervise them but this had not been in place for the last year. The registered manager was not a clinician and therefore would not be able to provide clinical supervision to staff of the same profession. There were no arrangements in place for staff to be able to access a person of a similar profession to theirs for clinical supervision if they wanted this. However, staff confirmed they felt well supported by their colleagues and felt that they were able to discuss any issues they were experiencing

with the team. Staff told us that there was a very open culture within the organisation and that they would often have informal chats about work which were not documented as formal supervision.

We did not see evidence of any staff receiving specialist training for their role within LANCuk. When we spoke to staff they told us that they had training in previous roles but not whilst at LANCuk. For example, the service did not offer any training around autism or attention deficit hyperactivity disorder as most of the sessional workers had full time roles within autism services in the NHS the registered manager presumed that they were receiving training at those jobs to be able to revalidate their registration. The registered manager told us that once a year the service requested that sessional staff provide proof of their training. However, there was no evidence of this in the staff files that we reviewed. This meant the registered manager could not be assured that staff were appropriately trained to meet the needs of the patient group.

There was no framework in place to manage poor staff performance. The managing staff performance policy did not describe how poor performance would be managed or lay out the stages in which this could be achieved. In addition, the policy failed to specify how staff performance, and especially the performance of sessional staff would be monitored. This was of particular concern given the lack of formal supervision sessions. The registered manager told us that if they had concerns over a staff members performance they would have an informal chat with them. However, this would not be documented. There were no examples that we were able to look at of managing poor performance from staff. This meant that we were not assured the service would promptly and effectively manage poor staff performance.

Multi-disciplinary and inter-agency team work

There was a monthly multi-disciplinary team meeting which was attended mainly by the staff that were on site. Sessional staff did not attend but the minutes of each meeting were sent out to all staff. There was a range of professional employed by the service on a sessional basis, this included nurses, doctors, occupational therapists, speech and language therapists and a life coach. Patients would initially be seen by a consultant or a nurse and then other disciplines were brought in as and when required. We saw evidence in the records we reviewed of appropriate involvement from other professionals on a case by case basis.

The centre had good links with GPs and local mental health services. The service leased with GPs for patients to gain a good history of the patient and for any other information they required.

Adherence to the MHA and the MHA Code of Practice

The service did not see patients who were detained under the Mental Health Act.

Good practice in applying the MCA

Staff we spoke to had a good understanding of the Mental Capacity Act relevant to their role. They could tell us the main principles and how they would assess this when meeting with patients to be sure they were able to give informed consent.

There was no specific policy around the Mental Capacity Act although there was a policy titled consent. However, this policy appeared to have been copied and pasted from elsewhere as the policy referred to “the trust” throughout which would indicate that of a policy for an NHS hospital trust. The policy also talked about eLearning modules and Mental Capacity Act training available at “the trust” which was not something LANCuk provided. There was also a section about clinical photography and conventional of digital video recordings which would not be relevant to LANCuk.

There was no monitoring of when clinicians had last received updates in the Mental Capacity Act 2005 (MCA 2005) or the Gillick Competency / Fraser Guidelines (guidance in obtaining consent from patients under 16) and training was not provided by LANCuk for permanent staff.

Are outpatient services (for people of all ages) caring?

Good

Kindness, dignity, respect and support

During our inspection we spoke to six patients that used the service and four carers. We also observed one clinic appointment for patient who was on the life coaching

course. From observing staff interactions with patients, we were able to see that staff treated patients with dignity and respect. Staff spoke about patients in a positive way and knew patients well.

Carers told us that staff were very respectful towards their loved ones and that they were genuinely interested in their welfare. One carer even told us they felt the service had gone "above and beyond" by putting them in touch with Universities that were doing research on their loved ones condition.

Patients comments were all positive about the provider. They told us that staff were kind and caring towards them and were available to give advice outside of appointment times if they needed to speak to them. All patients we spoke to told us that although they did not recall being given information about complaints they felt confident that if they wanted to raise a complaint they would do this and felt this would be listened to and acted upon. One person told us that what the centre had done for them was "life changing".

The centre had consulting rooms which were soundproof. We were in the room next door to an ongoing clinic throughout the day and could not hear anything that was being said. There was a confidentiality policy that staff were required to read which explained about confidentiality regarding records and discussions with patients. It also recognised the fact that if a patient disclosed something that was a safeguarding issue then confidentiality may need to be broken.

The involvement of people in the care they receive

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All patients we spoke to told us that they felt involved in their care. They told us that they were always given information relating to their care and given time to understand this prior to making any decisions about their care and treatment. Information about medications were provided to patients with information about benefits, side effects and adverse reactions. Patients told us they were always given a choice of treatments that were available for them (medication) and could take time to discuss this with carers or family prior to deciding.

Carers and family told us that when the patient wanted them to be, they were involved in their loved ones care. They told us they were invited into the initial assessment to give a history of the patient for example, childhood milestones and behaviour at school. For adults, they reported that they were not asked formally to bring a family member along but felt this was appropriate due to their age. When they asked if they could bring someone this was always welcomed.

Patients were not involved in recruitment of staff at the service. However, they did have opportunity to give feedback in a form following each appointment. There was also a comment box in the reception area where patients could leave comments regarding their experience at the service.

There were leaflets regarding the local advocacy service in the reception area.

Are outpatient services (for people of all ages) responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

The waiting times from referral to assessment were six weeks for urgent referrals and twelve weeks for non-urgent. We looked at eight records and found that these met the initial waiting times. Patients were offered appointment times which were suitable for them for example, at weekends. There were three members of administration staff who were available to answer the telephone when patients rang in. When we spoke to patients they told us that they were always able to speak to someone quickly if they rang the service or got a quick response when they emailed.

The team would contact people who were on the waiting list to offer an appointment time and date. As patients were seen within the set timescales (six to twelve weeks) it was not routine to contact people again in-between. However, some patients did tell us they had rang in-between to perhaps ask a question or confirm details of appointments and they reported they were always able to get through to the team quickly. We did not see any examples of when a

patient appointment was cancelled but if this did happen staff told us that they would contact the person and offer an explanation and an alternative appointment date immediately.

The facilities promote recovery, comfort, dignity and confidentiality

There was a full range of rooms at the centre to provide treatment and care for patients. There was a waiting room which contained information relating to autistic spectrum disorder and attention deficit hyperactivity disorder as well as local services, medications and other relevant information. There was no information displayed in the waiting area about the complaints procedure but there was a comment box. There were two interview rooms where patients could be seen and these rooms were decorated in calming colours with little stimulus to keep a calming environment throughout assessments.

Meeting the needs of all people who use the service

The premises were accessible for those with limited mobility and all services were provided on the ground floor. There were two steps into the building but there was a ramp available if people needed to use it.

All the information in the waiting area was in English. However, staff had access to interpretation and translation services. As well as face to face and telephone interpretation this included the ability to have documents and leaflets translated. Staff identified patients first language through referral information and were able to have relevant documents translated if this was required. We reviewed records and saw that translation and interpretation services had been involved with patients in the past where appropriate.

Listening to and learning from concerns and complaints

There were no complaints to the service within the twelve months leading up to our inspection However, patients we spoke to were not aware of the complaints procedure and we did not see this displayed whilst we were at the service. When we interviewed the registered manager, they told us that the complaints procedure was sent out with appointments. However, none of the patients we spoke to recalled receiving this. However, patients did tell us that they would feel more than comfortable raising an issue if they felt they had one with the service and that they felt confident this would be dealt with appropriately. Despite this it was difficult to see how the service would record minor issues that were raised by patients if this was done via email or over the telephone as this information was not transferred into the patient records to be monitored in any way. For example, one patient told us they had rang the service several times as they were waiting for an appointment and becoming anxious about this. This information was not documented in the patient file. This meant that the service did not have a framework to address or learn from informal and locally resolved complaints.

The service had a complaints policy which set out how complaints would be managed. This detailed that all complaints should be sent in writing or via email to the registered manager. It detailed timescales for responses and what would happen in the event of a delay. However, the policy directed patients to the Care Quality Commission or the relevant professional body such as the NMC or GMC if they were unhappy with the outcome of a complaint and this was not the correct place to direct people to. There was no procedure in place should a complaint come in about the registered manager as there was nobody else at a senior level to investigate a complaint of this nature. This meant that a subjective approach could not be ensured when investigating complaints of this nature.

As there were no complaints for us to review during inspection we were unable to see evidence of how learning from complaints would be shared. However, the policy states that this would be discussed with either the individual or the staff team at a meeting dependent on the complaint.

Are outpatient services (for people of all ages) well-led?

Inadequate

Vision and values

LANCuk had a mission statement in place which described its vision and values:

“LANCuk has a patient orientated approach, regularly audits its work and strives to continually improve the quality of service delivered. The ethos of LANCuk has long been to consider that it has a responsibility in increasing

factual professional and public awareness of neurobiological conditions such as AD/HD and Autism as part of the overall spectrum of mental health difficulties. It considers that it is important to emphasise the reality and real-life difficulties experienced by people with such untreated conditions and their impact on society generally".

Staff we spoke to were able to tell us the ethos of LANCuk and what they hoped to achieve which in general matched the values listed above. There was one director at the provider who was also the registered manager. Staff all knew who this person was and told us that they were present at the centre on a regular basis. They were also available on the telephone when they were not there.

Good governance

The provider did not have robust or effective systems to ensure the quality, safety and ongoing monitoring of service provision.

Patient records were incomplete and not contemporaneous. The care records system did not allow for the recording of daily contacts with patients, for example phone calls and emails. Records from patient assessments and consultations were shredded once a summary clinical letter had been produced. This meant that information pertinent to the care and treatment of patients was not always available.

There were insufficient checks to ensure that staff were suitably qualified and skilled to work with the patient group or to support them in their work. There were no mandatory training requirements for staff and no record of training staff had completed. Staff supervision and appraisal were not delivered in line with the providers policy. Relevant checks on staff qualifications and references was not available in staff files. There was no evidence that any staff had completed safeguarding training. The providers safeguarding policy was ineffective and reliant on the presence of the registered manager to raise referrals. It was not clear if potential safeguarding concerns had been missed because notes from appointments had been shredded and the only information available was in the form of summary letters.

There were ineffective procedures to assure the quality of the service and promote improvement. There was no formal audit programme in place. There were a few audits that had been completed but these were standalone audits and follow up audits had not been completed. There was a complaints process in place but this had not been communicated to patients when they first accessed the service. The complaints policy did not cover the management of informal complaints and provided incorrect information on what to do if an individual was unhappy with the outcome of a formal complaint. There was no identified process to respond to a complaint if the complaint involved the registered manager. There was a policy and process to support the reporting and review of adverse incidents. However, the service had not reported any incidents since the service opened

The provider had a risk register that staff could submit items to. However, we were unable to see what happened to mitigate these risks as there were no dates to say when action should be taken by. For example, one risk was around supervision and appraisal, the action to mitigate was regular appraisals, or 1:1 meetings and regular social occasions. There was no date to when this would be achieved by and how regular appraisals or one to ones would be implemented. There was also no date to review the risks to see how they had improved or deteriorated. We reviewed the minutes of the last three months multi-disciplinary team meetings and did not see the risk register discussed in any of those with regard to actions or updates on progress.

The registered manager had a good level of administration support to be able to carry out their role. As this was a small provider with one director and only two permanent members of staff the registered manager had enough authority to carry out their role.

Leadership, morale and staff engagement

Staff we spoke to told us they enjoyed their job and felt that they could raise issues without any fear of victimisation. Staff morale was high and staff told us they enjoyed going to work in a smaller service where they felt they could make a difference. The team were supportive of each other and were available to help colleagues if they had a question or query regarding a patient. We reviewed the minutes of the multi-disciplinary team meetings which were monthly and saw that an agenda item was to discuss any difficult cases for advice from colleagues the detail of the minutes was lacking but staff reported they found this helpful and that they could get ideas and tips from other staff. The provider had reported no bullying or harassment cases in the twelve months leading up to our inspection.

Inadequate

Outpatient services (for people of all ages)

Staff we spoke with told us that the service promoted an open and honest culture and could tell us how they would explain to patients if something had gone wrong. The duty of candour policy did explain how to manage incidents which met the criteria but it did not tell staff what the thresholds were for a duty of candour response. Despite this staff did show an open and honest culture in the way they worked and patients told us that they felt staff would explain to them if something went wrong in a sensitive way.

Commitment to quality improvement and innovation

We did not find any evidence of any innovative practice or involvement in research.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that they establish and operate arrangements to assess, monitor and improve the quality and safety of the services provided.
- The provider must ensure that they establish and operate a system that ensures all staff have the correct guidance and policies to evaluate and improve the practice.
- The provider must ensure they establish and operate arrangements to maintain an accurate, complete and contemporaneous record in respect of each patient maintaining a record of the care and treatment provided and act on any identified concerns.
- The provider must ensure the records system is used to record contact with patients and carers effectively, this includes recording or risks, safeguarding concerns and physical health investigations.
- The provider must ensure that staff are suitably qualified and experienced to carry out their role.
- The provider must ensure that staff employed have the qualifications, competence, skills and experience which are necessary for the work to be performed
- The provider must establish and operate a system to ensure all staff have appropriate supervision and an annual appraisal.
- The provider must ensure that appropriate checks on staff are carried out before they start working in the service to ensure they are suitable to work with patients.

Action the provider SHOULD take to improve

- The provider should consider installing a nurse call system in interview rooms so staff can alert others if there is a problem.
- The provider should ensure that there is a height measuring device available for when patients attend who require this for the prescribing of medication.
- The provider should ensure that there are arrangements in place should the situation arise where a complaint is made about the registered manager.
- The provider should ensure that information about the complaints procedure is given to all patients and is displayed in the service so patients can access this if required.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed because staff were not receiving supervision once per month in line with the supervision policy. Staff were not receiving an annual appraisal that was meaningful and reviewed six monthly as per the appraisal policy. This was a breach of regulation 18(2)(a) We issued a requirement notice to Learning assessment and neurocare Ltd.

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.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed. The provider failed to ensure that any persons employed had the qualifications, competence, skills and experience which were necessary for the work to be performed. None of the staff files we reviewed on inspection contained an up to date DBS None of the staff files we reviewed on inspection contained application forms, interview records or references One staff file we reviewed on inspection did not contain evidence on registration with the relevant body (NMC) Sessional staff files did not contain evidence of ongoing training relevant to the role at their permanent job - there was no training deemed mandatory for the two permanent staff at LANCuk. This was a breach of regulation 19(1)(a)(b) and 19(2) We issued a warning notice to Learning assessment and neurocare Ltd telling them that they must improve in these areas by 12 September 2018.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA (RA) Regulations 2014 good governance.** Governance systems did not ensure that the service assessed, monitored and mitigated risks and improved the quality and safety of services. This was because, records were not contemporaneous. The patient records system contained minimal information. Telephone calls and emails were not recorded. When clinicians carried out an assessment there was a letter generated and sent to the patient but the notes taken during the actual appointment were not kept anywhere so these were destroyed once the letter was typed. The safeguarding policy was not clear on who to contact and what to do in the event of someone disclosing a safeguarding concern, records were not used to record telephone calls, emails and notes made from appointments so it was unclear how these would be documented and follow ups reviewed and monitored. The registered manager was asked to complete safeguarding training as part of the registration process and this was not done. Documentation of what was done following physical health concerns was again not kept in the patient record. Therefore, the inspection team were not clear on any actions taken following physical health checks as there was nowhere on the records system to record investigations into physical health. This was a breach of regulation 17(1)(2)(c)

This section is primarily information for the provider

Enforcement actions

We issued a warning notice to Learning assessment and neurocare Ltd telling them that they must improve in these areas by 12 September 2018.