ADDMIRE Clinic

Inspection report

West Byfleet Consulting Rooms
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KT14 6DH
Tel: 01932344004
www.addmire.org/

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, 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 to people's needs?	Good
Are services well-led?	Inadequate

Overall summary

This service is rated as Requires improvement overall.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Inadequate

We carried out an announced comprehensive inspection at ADDmire Clinic on 17 February 2023 as part of our inspection programme. This was the first inspection of this service.

The ADDmire Clinic is a specialist independent assessment and treatment clinic for children with neurodevelopmental needs, Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD).

The managing director is the registered manager. A registered manager is a person who is registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We spoke to nine parents and carers of patients who were using the service and they were complimentary about the service. They described compassionate and kind staff who offered effective treatment and support. Parents and carers told us that they have been involved in decisions about care and treatment for their children and they were listened to. However, some parents told us that they had to wait for a long time for an appointment, and a parent felt that the service can improve further by discussing other strategies apart from medication.

Our key findings were:

- The service did not always have clear systems to keep people safe and safeguarded from abuse. Staff did not assess risk appropriately or follow good practice with respect to patient safety.
- The service did not have systems and arrangements in place for managing prescriptions to minimise risks. The service was not carrying out any medication audits to assure themselves about the quality of their prescribing practices. Staff did not always ensure that appropriate physical health monitoring was carried out where required.
- Staff did not always assess the needs of patients and deliver care and treatment in line with national standards and guidance relevant to their service. The service did not actively participate in quality improvement work.
- The service did not have adequate governance processes in place, that allowed staff to review practice and risk areas for assurance, and to improve quality.
- There were no policies and procedures in place to identify what preemployment checks should be carried out for staff, and how these should be recorded in staff records. There was not a robust process in place, for the service to assure themselves that all staff were appropriately qualified and trained.
- There were no records of clinical supervision for staff. We found no evidence that clinical supervisions was happening, or how this was monitored.

Overall summary

- The service did not always obtain consent to care and treatment in line with legislation and guidance.
- The service did not always establish proper policies, procedures and activities to ensure safety and assure themselves that they were operating as intended. For example, there was no robust process in place to ensure policies and procedures were thorough, regularly updated by competent staff, and up to date with relevant national guidance.
- There was a lack of robust record keeping. The clinical notes we saw on the electronic patient records did not include a clear record of relevant discussions or updates.
- The service was not assuring themselves that equipment was maintained according to manufacturers' instructions, and safety and emergency equipment checks were promptly completed.
- Staff were not always aware of what reasonable adjustments should be made to the environment, to meet all patients needs when needed. The provider felt that they were able to make reasonable adjustments for patients, when needed.
- The service did not have a policy in place regarding duty of candour, so it was unclear how the provider ensured compliance with the requirements of the duty of candour.

However,

- Staff treated patients with compassion and kindness, and understood the individual needs of patients. They helped patients to be involved in decisions about care and treatment.
- Most patients were able to access care and treatment from the service within an appropriate timescale for their needs.

Following this inspection, we served the provider with a Warning Notice, because we found that significant improvement was needed to ensure that the service had adequate governance processes in place, that allowed them to review practice and risk areas for assurance, and to improve quality. The lack of governance arrangements meant that not all risks were identified and acted upon in a timely way. The Warning Notice required the provider to make improvements to meet the legal requirements set out in the Health and Social Care Act by 09 June 2023.

In addition to the improvements identified in the Warning Notice, the areas where the provider **must** make improvements as they are in breach of regulations are:

- The service must ensure that there are clear systems in place to keep people safe and safeguarded from abuse. Robust risk assessments must be completed to demonstrate that risks are managed effectively to keep all patients safe. Regulation 12
- The service must ensure that there are systems and arrangements in place for the proper and safe management of medicines, and that the physical health of patients is assessed, monitored and managed effectively in accordance with patients' needs. Regulation 12
- The service must ensure that care and treatment of service users must only be provided with the consent of the relevant person. Regulation 11
- The service must ensure that there are appropriate arrangements in place to meet the requirements set out in Regulation 20, Duty of Candour, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see full details of the regulations not being met at the end of this report.

The areas where the provider **should** make improvements are:

- The service should ensure that staff assess needs and deliver care and treatment in line with standards and guidance relevant to their service.
- The service should ensure that staff are aware of what reasonable adjustments could be made to the environment, to meet all patients when needed.

Overall summary

Serena Coleman

Interim Deputy Director

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a CQC support inspector, a specialist advisor and an expert by experience who spoke with parents and carers remotely.

Background to ADDMIRE Clinic

The service is provided by Addmire Ltd.

Services were provided both in person and virtually. The appointments in person were usually taking place on Wednesdays and Fridays from a leased consulting room within shared premises at the following address:

West Byfleet Consulting Rooms,

Madeira Road,

West Byfleet,

KT14 6DH.

We visited the site as part of the inspection.

The provider is registered with the Care Quality Commission to provide the following regulated activity:

- Treatment of disease, disorder or injury

The service was set up in 2017 and offers assessments and treatment to children with neurodevelopmental needs. The service specialises in the diagnosis and treatment of ADHD and ASD. Most of their work is with children with ADHD. The service was developed to meet unmet demand for children's ADHD/ ASD assessments, diagnosis and treatment.

Services are led by the clinical director, a consultant neurodevelopmental paediatrician, who has previously worked at a local NHS ADHD clinic for many years. The clinical director develops treatment plans following assessment and these may include medication. The consultant is supported by a speech and language therapist, a clinic co-ordinator, who provides support in the clinic, a clinic manager, an administrator and the registered manager. There is also an ADHD specialist nurse who works alongside the service.

Referrals are received directly from parents and carers and from other sources, such as GPs. Patients and carers are responsible for funding the assessments and treatment.

Initial assessments take place in person, but any follow ups may be virtual. Most patients and parents are local. The service accepts referrals of children and young people between the age of three to 19 years of age.

https://www.addmire.org/

How we inspected this service

Before the inspection visit, we reviewed information we held about the service. During the inspection we:

- visited the premises and looked at the quality of the environment,
- observed an appointment between the consultant and a child accompanied by their parent,
- spoke with the registered manager, the clinical director, the speech and language therapist, the clinic co-ordinator, the clinic manager, and the ADHD specialist nurse,
- spoke with nine parents and carers of patients who were using the service,
- reviewed 22 patient records,
- reviewed prescriptions management,
- reviewed four staff records,
- reviewed information and documents relating to the operation and management of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?

- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Requires Improvement

Are services safe?

We rated safe as Requires improvement because:

Safety systems and processes

The service did not always have clear systems to keep people safe and safeguarded from abuse.

- The providers' landlord conducted safety and environmental risk assessments and acted to follow up any issues to ensure the premises were safe. The service had adopted some of the landlords policies and procedures, such as the 'emergencies policy and procedures' and the 'infection control policy'. We found no information about how the provider communicated these policies to staff, however, some of the staff we spoke with were aware of some emergency procedures, such as fire drill arrangements.
- We found no evidence of how the provider was assuring themselves that equipment was maintained according to manufacturers' instructions and safety checks were promptly completed. Emergency equipment were being checked by the landlord, however, the service was not assuring themselves that these checks were done.
- There was an effective system to manage infection prevention and control. The building cleaning and maintenance was managed by the landlord. We reviewed the cleaning checklist and saw that cleaning was carried out daily. All areas of the environment were visibly clean.
- The service had a safeguarding policy and procedures for children and young people in place, however, it was not clear whether it was regularly reviewed, or how the provider assured themselves that the policy was up to date with relevant national guidance. Not all staff had completed safeguarding children training at a level appropriate to their role. For example, a staff member who was working with children and could potentially contribute to assessing and evaluating the needs of the children had completed level two safeguarding training, instead of level three, as per the relevant guidance.
- We were not assured that all staff knew how to identify and report safeguarding concerns, and were aware of their responsibilities and what action to take. For example, we observed that during a session, a child appeared to have self-harm marks on their arm, but staff did not discuss or indicate whether any action was necessary. We also found that there were no risk assessments in place to explain how this risk was managed and escalated, when appropriate. However, following the inspection, the provider informed us that staff discussed this incident with the consultant as soon as possible following the consultation. The consultant also contacted the family and relevant advice was given. Some staff told us that they were not sure how the team would identify whether a child was at risk of harm, however, they were aware of the signs of abuse and were able to explain how a safeguarding referral would be made if necessary. Staff told us that any information related to safeguarding concerns, or children on the child protection register was explored during the referral process. The clinical director was the designated safeguarding officer for ADDmire Clinic.
- The service had systems in place to assure that an adult accompanying a child had parental authority.
- We found no evidence that the provider consistently carried out staff checks at the time of recruitment and on an ongoing basis. There were no policies and procedures in place to identity what preemployment checks should be carried out and how these should be recorded in staff records. We reviewed four staff files and found information recorded in the files was inconsistent. Some files included information that others did not, for example, pictures of Disclosure and Barring Service (DBS) certificates. Some of these had been issued for other employers and there was not a relevant policy in place to explain when and how often these were checked. The staff files did not always include other relevant information, such as staff references, or information of clinicians registration with appropriate bodies.
- The provider informed us that all staff were subcontracted to carry out work for the service, however, the employment arrangements were not always clear. For example, the service kept a staff file for a person who was neither directly employed, nor directly invoicing the service for their work.

Risks to patients

Requires Improvement

Are services safe?

There were not always systems in place to assess, monitor and manage risks to patient safety.

- Staff were not carrying out any risk assessments to identify and mitigate potential risks. Some staff told us that the service was gathering information related to patient risks, however, we found no evidence that such information was used to complete risk assessments. Staff were not carrying out risk assessments even when risk had been identified. For example, we observed that a child had run to the fire escape in the waiting area and had a history of fleeing. However, no relevant risk assessments were in place. Following the inspection, the provider informed us that they were taking action to appropriately record patient risks.
- The provider was reviewing the number and mix of staff needed and any action taken was in response to the needs of the service. For example, a speech and language therapist was involved in all autism assessments. The provider told us that they also worked with other professionals when required, such as psychologists. All new referrals were reviewed by the clinical director, and the clinic manager booked and managed patient appointments, collected information for referrals, and sent relevant questionnaires.
- The provider told us that the service would transfer or decline high risks patients. However, the service did not have a referral criteria in place to identify the level of patient risk the service could accept. The provider told us that they did not have a specific policy in place and any exclusion criteria, because patients were seen on an individual basis. Some staff told us that they had been regularly liaising with the clinical director to discuss concerns and signpost or refer patients to other services when needed.
- There were suitable medicines and equipment to deal with medical emergencies which were stored appropriately and checked regularly by the landlord. We saw that there was a resuscitation trolley that was checked weekly and emergency medicines checked daily. However, the service did not have any arrangements in place to assure themselves that these checks were promptly completed. The service had a first aid and medical emergencies policy in place which explained that the landlord was responsible for adequate first-aid provisions for all patients, families and staff during working hours.
- Indemnity arrangements covered the clinical practice, however, there was no indemnity insurance cover for the provider.

Information to deliver safe care and treatment

Staff did not always have the information they needed to deliver safe care and treatment to patients.

- Individual care records were not always managed in a robust way. We reviewed 22 patient records and saw that although they were stored securely on an online electronic system, there was consistently lack of robust record keeping. It seemed that not all clinicians were directly adding to the system. We found no clear record of discussions or updates, and no continuity in process from referral through to assessment and diagnosis, along with no consistent quality assurance of record uploads and storage.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. We saw evidence that correspondence had been sent to parents and cares of patients who were using the service and their GPs.

Safe and appropriate use of medicines

The service did not always have reliable systems for appropriate and safe handling of medicines.

Requires Improvement

Are services safe?

- The service did not have systems and arrangements in place for managing medicines to minimise risks. The provider did not monitor the use of prescriptions and did not have policies and procedures in place to demonstrate how the service was managing potential errors, or missing prescriptions. We reviewed 22 patient records and found photographs to evidence the prescriptions, however, the serial numbers on six prescriptions were not shown. The provider told us that the prescription pads were kept in a locked safe in their home.
- The service did not carry out any medicines audits to ensure prescribing was in line with best practice guidelines, and to assure themselves about the quality of their prescribing practices. No medicines were stored on the premises.
- Staff did not always ensure that appropriate physical health monitoring was carried out where required. The patients records we reviewed were lacking evidence of appropriate physical health monitoring. Side effects of medication were not consistently monitored, including weight loss and low blood pressure. We found that five patients records showed that children had significant weight loss, however, there were no evidence of further review, or medication changes. For example, we found that one child was losing weight, however, the increase in medication was still actioned. We were unable to identify any follow ups, or shared care, and it appeared that the medication was prescribed and increased during a period of school exams.
- During the inspection visit, we observed that the consultant increased the medication for a child, following feedback from the parent that the child had relapsed. However, the child had not been taken their medication for the past two months. The parent advised that they had needed to order medication from elsewhere as they were unable to fulfil the prescription locally for two months. The consultant was not aware that the patient had not been taking the medication prior to this appointment. No offer of advice was given to the patient should this happen again. The consultant and parent reviewed the symptom tracker which showed breakthrough symptomology. The consultant increased the medication further without considering that the breakthrough symptomology may have resulted from the lack of availability for the medication locally.
- We found that seven patient records were transferred via shared care during titration, without a period of supervision documented to evidence stabilisation on medication. There were no relevant records between appointments in person. Virtual meetings and meetings in person were on a rolling rota, so there may be a considerable time between face to face meetings during titration.
- We found no protocols or procedures in place to explain how the service was verifying the identity of patients.

Track record on safety and incidents

- There had been no serious incidents reported at the service. We saw that incidents and risks were included as a standard agenda item on a template used for combined clinical governance and team meetings, however, no risks had been identified. The provider told us that they did not have any incidents, however, we were not assured that incidents, including near misses, were identified and reported appropriately. The service did not have an incident management policy in place.
- Staff did not complete comprehensive risk assessments in relation to safety issues. The service had a risk register in place, however, it did not include all potential risks as identified by the provider during discussions with us on the day of the inspection. For example, risks associated with lone working for staff visiting patients at their homes. This meant that the provider was not aware of all potential risks associated with the operation of the service and there were no action plans in place to mitigate them.

Lessons learned and improvements made

It was unclear how the service learned and made improvements when things went wrong.

- The provider did not have an incident management policy in place. The provider was unable to demonstrate how they would learn or improve following incidents.

Requires Improvement

Are services safe?

- The provider did not have a duty of candour policy in place that guided staff in how to ensure the duty of candour principles were upheld.
- The provider told us that they were receiving medicine safety alerts via emails which were then checked by the registered manager and the clinical director.

Requires Improvement

Are services effective?

We rated effective as Requires improvement because:

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice, however, clinicians did not always assess needs and deliver care and treatment in line with standards and guidance relevant to their service.

- The consultant carried out specialist assessments for Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD), such as the Autism Diagnostic Observation Schedule (ADOS). They also used diagnostic screening tools, such as the QBTest, which aids the assessment of ADHD. The provider informed us that the consultant was keeping up with current evidence based practice by reading relevant journals, attending conferences, and being a member to groups and organisations, such as the Royal College of Paediatrics and Child Health and the Association for Child and Adolescent Mental Health.
- Clinicians did not always have enough information to make or confirm a diagnosis. The provider told us that staff assessed needs and delivered care in line with relevant and current evidence-based guidance and national standards, such as the National Institute for Health and Care Excellence (NICE) best practice guidance. However, we found that the diagnosis of children and young people with autism, for example, did not always meet NICE guidance. We reviewed 22 patients records and found that three children had been diagnosed with autism. However, we only found evidence of one completed ASD assessment. We also found that the multi-disciplinary team (MDT) involvement for ASD assessments, did not have the core recommended membership, as it did not include a psychologist. The provider explained that they felt that this was more applicable to NHS teams, and they were involving a psychologist when required. Their MDT consisted of the consultant and a speech and language therapist, involved in all autism assessments.
- MDT involvement to inform assessments were not always evidenced in patient records. MDT recording was poor, sometimes a single sheet was used which was not signed or dated. We found three records with MDT involvement, which were not consistent with best practice and did not include who attended, were difficult to read and two were not signed. One that was signed did not have the clinician's name printed, so we could not confirm who wrote it. Following the inspection, the provider submitted a new form that has been developed to better capture the information shared by the MDT.
- We found that 13 patient records included an ADHD diagnosis without evidence of combined use of the QBTest, or other tools, such as the Conners Comprehensive Behaviour Rating Scales, to support diagnosis. We found no evidence that observations in other settings have been completed by qualified practitioners, as per best practice guidance, in order to support diagnosis in more than one environment. This meant that the criteria for diagnosis was only based on questionnaires and reports from parents and carers.
- None of the records we reviewed included an assessment of the parents/ carers needs, as per NICE best practice guidance.
- We saw no evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

The service was not actively involved in quality improvement activity.

- The provider told us they made improvements through the use of completed audits. For example, they told us that an audit was carried out in January 2022 to determine whether interviews based on the Diagnostic and Statistical Manual, fifth edition (DSM-5), was better than the Autism Diagnostic Interview – Revised (ADI-R). The service concluded that the

ADI-R should be adopted. However, we saw that this audit was a record of considerations which informed the decision making with regards to which interviews would be used by the service. There was not an audit programme in place, or evidence of any completed clinical or administrative audits to demonstrate how the service assured themselves that services were being provided in line with standards and improvements were being made.

- We found no evidence of actions the service had taken to resolve potential concerns and improve quality. The service did not have a service improvement plan in place.
- The provider explained that the service was experiencing difficulties to collect information about care and treatment to make improvements. The provider told us that they had unsuccessfully tried various systems in the last year to receive feedback from parents and carers, but they had only received a few responses which were positive.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. However, we were not assured that the provider had a robust process in place to assure themselves that all staff were appropriately qualified and trained.

- The staff members have been working for the service for many years and the provider informed us that they had worked in other similar NHS services in the past. However, the provider did not have a robust process in place to assure themselves that all staff were appropriately qualified and trained. For example, the provider could not always provide copies of training certificates of staff.
- The staff records we reviewed did not include all qualifications, information about staff registrations with relevant bodies, or whether clinical staff were up to date with their revalidations. However, staff we spoke with confirmed that they were appropriately registered with the relevant bodies, such as The Health and Care Professions Council (HCPC). The clinical director was registered with the General Medical Council.
- We found no evidence that the provider had an induction programme for staff, or that they had received an induction. This meant that staff were not always aware of the provider's policies and procedures and how to effectively apply them. For example, a member of staff told us that they were unsure whether the service had policies and procedures in place. Another staff member told us that there was a lone working policy in place, however, this was not the case at the time of the inspection visit.
- The provider had a document in place called 'training expectations for staff working with ADDmire Clinic 2022', which highlighted the training expectations for staff, and explained that relevant training staff received while working for another employer would be valid for work at ADDmire Clinic. However, it was not clear what arrangements the service had in place to encourage and give opportunities to staff to attend training and further develop. For example, it was stated in that document that, all staff needed to have information governance or data safety awareness training, updated at least every three years. We did not find evidence that all staff had completed this training. Some staff told us that they had not attended any ADHD or ASD training despite directly working with patients with ADHD or autism.

Coordinating patient care and information sharing

Staff did not always work well with other organisations, to deliver effective care and treatment.

- We did not see any evidence of patients or carers declining to give consent to share details of their consultation and any medicines prescribed with their registered general practitioners (GPs) on each occasion they used the service. Staff were aware of the importance of sharing information with patients' GPs. Staff said that if a patient declined to give consent they would consider the individual case and may decline to treat the patient. We saw that letters were sent to parents and carers and GPs.

Requires Improvement

Are services effective?

- We found limited evidence that the service was liaising with other relevant services, such as schools. The provider told us that they were mainly expecting the parents to liaise with schools about the diagnosis.
- The service did not always ensure they had adequate knowledge of the patient's health, any relevant test results, and their medicines history. We did not find evidence in patients records that such information was collected prior to appointments. Staff told us that they had been regularly liaising with the clinical director to discuss concerns and signpost or refer patients to other services when needed.

Supporting patients to live healthier lives

Staff were consistent and proactive in empowering patients, and supporting them to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice so they could self-care. Parents and carers told us that they were given relevant resources and information for support groups.
- Risk factors were highlighted to patients. For example, parents and carers told us that the right treatment was given following thorough discussions with the consultant.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs. For example, staff told us that they had liaised with the clinical director to refer to patients to other services, such as GPs and Child and Adolescent Mental Health Services (CAMHS). The service referred patients to an ADHD specialist nurse for support following diagnosis, to give information and advice to parents, and, in some cases, to help the child to understand their diagnosis.

Consent to care and treatment

The service did not always obtain consent to care and treatment in line with legislation and guidance.

- Staff did not always understood the requirements of legislation and guidance when considering consent and decision making. None of the patient records we reviewed included consent for assessment or treatment. We found no completed consent forms, or clinical notes to demonstrate relevant discussions had taken place with the patients. We found no evidence of how young persons were involved in conversations around consent. The provider told us that by coming to the clinic, parents and carers imply that they consent for assessment and treatment. They also told us that written consent is only needed for data sharing, however, we found no recorded information about consent to share information. The only signed consent was for the QBTest.
- Staff told us that when they were visiting patients at their homes, they shared with their partners the addresses, for safety reasons related to lone working. We found no risk assessments, or evidence of agreements for staff to share such information. The provider's 'confidentiality and record keeping policy' did not include any relevant information of how this was managed. One of the statements included in this policy stated that, if the decision is taken (by staff) to disclose information, that decision must be justified and documented. We found no evidence of this.
- Staff told us that they recorded their home visit sessions on their phones and then typed up notes, added them to the assessments and then deleted the recordings. Staff said that the clinic manager gained consent for this when visits were booked, however, we found no evidence that this was happening. We also did not find a policy or procedure in place, around the use of mobile phones for staff to record sessions with patients and their families.

Good

Are services caring?

We rated caring as Good because:

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from parents and carers was positive about the way staff treated people. They said staff treated them with kindness and compassion. Most patients and carers were complimentary about the service, both in the quality of care and treatment from clinicians and in the customer service and appointment management from administration staff.
- Staff understood the needs of the patients and their families. Parents and carers confirmed that care and treatment was tailored to their individual needs and circumstances. Some parents and carers told us that the service communicated well with patient and family and their child felt that they were listened to.
- The service gave patients timely support and information. Some parents told us that the service gave them the opportunity to have an assessment and diagnosis in a timely manner, and the material and links given to them by the service were up to date and relevant.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

- All parents and carers we spoke with reported that they felt supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- Staff involved families in the assessment and planning of care and treatment. Parents told us that treatments and medication was explained in a way they understood. However, staff were unable to explain how the service ensured that all patients communication needs were being met, despite acknowledging that the majority of patients had such needs.
- The service did not provide interpretation services for patients who did not have English as a first language.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect. All consultations in person were held in private at the dedicated consulting room the service was using. All parents and carers told us that staff treated them with dignity and respect and that the consulting room was appropriate.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

Responding to and meeting people's needs

The service organised and delivered services to meet patients' needs.

- Staff understood the needs of their patients and supported their needs. For example, all the patients and carers we spoke with, told us that they felt listened to and were offered the right treatment for their needs at the time.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. The facilities and premises were mostly appropriate for the services delivered. There was wheelchair access and disabled toilets were available in the waiting area where the consulting room was located. The provider felt that they were able to make reasonable adjustments for patients when needed, however, we were not assured that all staff were always aware of what reasonable adjustments should be made to the environment, to meet all patients' needs. For example, the lighting of the consulting room could not be adjusted for persons with sensory sensitivities, if needed.

Timely access to the service

Most patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- Most patients had timely access to initial assessment and treatment. A parent told us that they were initially told that they had to wait seven months for an appointment, but the service offered them an appointment after eight weeks because of a cancelation. Another parent told us that they did not had to wait long as the service offered them an appointment during a bank holiday which they found helpful. However, some parents told us that they had to wait around six months for an appointment and a parent felt that this was long time to wait for a private clinic. Families typically waited about 6 to 8 months for a new assessment. The provider told us that they were striving to not have a longer waiting list than that. They also told us that they had a lot of pressure to see families as soon as possible.
- Delays and cancellations were minimal and managed appropriately. Some parents told us that the service offered cancelled appointments to families to minimise waiting times. Most of the parents and carers we spoke with told us that appointments mostly run on time and there was some flexibility with bookings. None of the parents reported any problems with the service's appointment system.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- The service had complaint policy and procedures in place. We saw that the template the service was using for their clinical governance and team meetings, included a standard item to discuss feedback received, but the provider informed us that the service have not had any complaints in the last 12 months.
- Most of the parents and carers we spoke with, felt confident that if they ever wanted to raise a concern they would contact the clinic directly. However, some parents told us that they were not clear whether they had received information about how to make a complaint.

Inadequate

Are services well-led?

We rated well-led as Inadequate because:

Governance arrangements

There were no clear responsibilities, roles and systems of accountability to support good governance and management. Our findings from the other key questions demonstrated that governance processes did not always operate effectively and risk was managed well.

- Structures, processes and systems to support good governance and management were not clearly set out, understood and effective. For example, the service did not have a robust process in place to assure themselves that all staff were appropriately qualified and trained. The provider could not provide copies of training certificates of staff who were completing tests to inform the assessment process.
- Leaders did not always established proper policies, procedures and activities to ensure safety and assure themselves that they were operating as intended. For example, the service did not have a robust process in place to assure themselves that policies and procedures were thorough, regularly updated by competent staff, and up to date with relevant national guidance.

Managing risks, issues and performance

There was no clarity around processes for managing risks, issues and performance.

- There was not an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. The service were not carrying out any risk assessments, the risk register did not include all risks, and it was unclear how the service was identifying potential risks and how was mitigating them. For example, there was no lone working policy, or relevant arrangements, in place, despite staff making home visits. Following the inspection, the provider confirmed that they were aware of the lone worker situation and submitted a newly created policy for lone working. However, the policy was not thorough and did not include actions the provider would take to ensure the safety of staff.
- Performance of clinical staff could not be demonstrated through audit of their consultations, prescribing and referral decisions. We found no evidence on how the provider were assuring themselves that the work completed by staff was quality checked. We found no evidence that the service completed any clinical or administrative audits to demonstrate how improvements were being made.
- There was not clear evidence of action to change services to improve quality. The service did not have an improvement plan in place to indicate areas that needed improvement and any action taken.
- We found no evidence that the service had a business continuity plan or arrangements in place.

Culture

The service did not always demonstrated a culture of high-quality sustainable care.

- Processes for providing all staff with the development and support they needed, were not always in place. We saw evidence that staff had recently received an appraisal, however, we found no evidence of staff receiving any supervision. Staff we spoke with confirmed that they did not receive any supervision through the service. The provider had informed us that clinical peer discussion/supervision for the consultant was done with another specialist consultant paediatrician in person, approximately every three months. However, we found no evidence of these during the inspection. Following the inspection, the provider submitted two records named 'peer review meeting', between the two consultants, one held in November 2022 and the second a few days after our inspection visit.

Inadequate

Are services well-led?

- It was unclear how the service promoted equality and diversity. A relevant policy was not in place and we did not find any evidence that any of the staff had received equality and diversity training.
- The service did not have a policy in place regarding duty of candour, so it was unclear how the provider ensured compliance with the requirements of the duty of candour.
- Some staff told us that there was good communication with the directors of the service and felt comfortable to raise concerns if needed. The provider had a whistle blowing policy in place.

Leadership capacity and capability

- The service was led by the consultant paediatrician who was also the clinical director of the service. The managing director of the service, who was also the registered manager, managed all the operational aspects of the service.
- Leaders were not always knowledgeable about issues and priorities relating to the quality of services. The service held combined clinical governance and team meetings and a template was used with standard agenda items. However, it was not clear how regular these meetings took place and there were no action plans to indicate whether any actions needed to be completed, and what were the timeframes and outcomes.
- Leaders were visible and approachable. The clinical director and registered manager worked closely with all staff to ensure the smooth running of the clinic.

Vision and strategy

The service did not have a strategy to deliver high quality care and promote good outcomes for patients.

- The provider told us that the vision of the service was for each child and young person with ADHD or autism to thrive following their evidence-based assessment, diagnosis and treatment, and to provide quality and compassionate care, based on up to date research evidence. Leaders described to us challenges and concerns, which included the clinic's capacity to accept new patients and the future ability of the directors to continue running the service. However, the service did not have a strategy, or a relevant plan to demonstrate how would achieve priorities.
- Staff participated in the clinic's clinical governance and team meetings. They told us that there were virtual team meetings where they discussed general information and how to improve the service, however, we found no evidence of these and it was unclear how staff involved in service development and clinical governance. The provider kept minutes of some clinical governance and team meetings, however, we did not find any minutes of the virtual team meetings mentioned by staff.

Appropriate and accurate information

The service did not always have appropriate and accurate information.

- It was unclear how quality and operational information, including the views of patients and their families, was used to ensure and improve performance. We found no evidence of completed patient surveys, however, the provider told us that they were unsuccessful in their efforts to collect feedback over the past year.
- We found no evidence that the service needed to submit, or submitted data or notifications to external organisations as required.
- There were not always robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

Inadequate

Are services well-led?

- It was not clear how the service encouraged and heard views and concerns from the public, patients, staff and external partners and acted on them to shape services and culture. We found no evidence that the service had systems in place to receive such information and whether they had acted on them when required.

Continuous improvement and innovation

- There were no evidence that the service made use of internal and external reviews of incidents and complaints, and that learning was shared and used to make improvements. The service did not have a policy in around incident management.
- There was a focus on continuous learning and improvement. The provider informed us that the consultant paediatrician was publishing papers in journals, and was a PhD candidate in medical humanities, a topic which the provider felt it was closely related to ADHD.

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 11 HSCA (RA) Regulations 2014 Need for consent The service did not ensure that care and treatment of service users was always being provided with the consent of the relevant person.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not ensure that there were clear systems in place to keep people safe and safeguarded from abuse. Robust risk assessments were not completed to demonstrate that risks were managed effectively to keep all patients safe. The service did not ensure that there were systems and arrangements in place for the proper and safe management of medicines, and that the physical health of patients was assessed, monitored and managed effectively in accordance with patients' needs.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour The service did not ensure that there were appropriate arrangements in place to meet the requirements set out in Regulation 20, Duty of candour, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not ensure that the service had adequate governance processes in place, that allowed staff to review practice and risk areas for assurance, and to improve quality. The lack of governance arrangements meant that not all risks were identified and acted upon in a timely way.