Oxford ADHD Centre Ltd

Oxford ADHD Centre

Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 7 November 2017 to ask the service the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this service was not always providing safe care in accordance with the relevant regulations.

Are services effective?

We found that this service was providing effective care in accordance with the relevant regulations.

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this service was providing responsive care in accordance with the relevant regulations.

Are services well-led?

We found that this service was providing well-led care in accordance with the relevant regulations.

Background

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

This was the first inspection undertaken at this service.

Oxford ADHD Centre is an independent clinic in Oxford for children and adults withAttention Deficit Hyperactivity Disorder (ADHD), Autism Spectrum Disorder (ASD) and related conditions, such as specific learning difficulties, anxiety and depression. It was started in February 2016. Assessments are available to identify any diagnoses of these conditions and can lead to treatment and management plans including treatment with medicine if appropriate. There are trained clinicians who provided workshops for patients and their parents or guardians. Patients could request an assessment privately for a fee and the centre received referrals from NHS child and adolescent mental health services (CAMHs). NHS referrals were for assessment only, and a report of the assessment outcome was sent to patients, parents/guardians and to CAMHs, with proposed measures which could support those patients, including treatments.

The centre used sub-contracted staff including registered clinicians (for example, clinical psychologists and nurse prescribers) to undertake assessments and provide care.

Summary of findings

The services were provided from ground floor premises. The premises were easily accessible and could be accessed by wheelchair users and those with limited mobility.

There is a registered manager in post. A registered manager is a person who is registered with the Care Quality Commission 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 received 10 individual patient comments, sent directly to CQC prior to the inspection and three comment cards filled out by parents attending the service. All of the feedback we received from parents/carers or patients was positive regarding the services. Feedback was particularly positive regarding the caring and kind nature of staff, at a time of stress and difficulty for parents and patients.

Our key findings were:

- The provider had systems in place to identify and learn from risks in order to improve services where necessary.
- Most risks associated with the provision of services were well managed. However, there was not a full assessment of the potential risks posed by medical emergencies.
- Prescribing was undertaken safely, although the process for initialising patients on medicines was in the process of being reviewed.
- Assessments of patients' potential conditions were thorough and followed national guidance.
- Patients received full and detailed explanations of any diagnoses and treatment options.
- Care was well planned and coordinated.
- The service was caring, person centred and compassionate.
- Services were delivered in an age appropriate way.
- The broader needs of patients were considered alongside any treatment or therapy needs.
- There were processes for receiving and acting on patient feedback.
- There were adequate governance arrangements in place in most aspects of the service.
- Clinicians demonstrated they had the skills and experience necessary to deliver care and treatment. However, there was no ongoing system in place to monitor staff training.

We identified regulations that were not being met and the provider must**:**

- Ensure care and treatment is provided in a safe way to patients.

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

There were areas where the provider could make improvements and should:

- Identify a system to monitor the ongoing training of staff who provide services to patients, in order to ensure they have the skills and knowledge required to provide care safely and effectively.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?
We found that this service was not providing safe care in accordance with the relevant regulations.

We have told the provider to take action. You can see full details of this action in the Requirement Notices section at the end of this report.

The impact of our concerns is minor for patients using the service, in terms of the quality and safety of clinical care. The likelihood of this occurring in the future is low once it has been put right.

The provider identified, assessed and mitigated most risks to patients. However, there were risks associated with prescribing which had been assessed but the process had not yet been amended. The potential medical emergencies which may occur and processes to manage these were not identified and planned for. There were systems to learn from incidents and events. Safeguarding processes were in place and staff had relevant training. The premises and equipment were well maintained and safe.

Are services effective?
We found that this service was providing effective care in accordance with the relevant regulations.

Assessments of patients' needs and documentation related to diagnosis and treatment was thorough and comprehensive. The centre proposed person centred treatment in line with national guidance. There were a broad range of clinicians who provided a highly experienced team for the diagnosis and treatment of ADHD and autism. Although qualifications were checked, there was not a system to ensure sub-contracted staff maintained skills and experience on an ongoing basis. Consent procedures were in place and these were in line with legal requirements. There was an appropriate system for recording and updating patient care and treatment information.

Are services caring?
We found that this service was providing caring services in accordance with the relevant regulations.

The provider had considered the potential needs and emotional difficulties faced by patients and their families in undergoing assessment and treatment. According to patient feedback, services were delivered in a compassionate and caring manner and their privacy and dignity was respected.

Are services responsive to people's needs?
We found that this service was providing responsive care in accordance with the relevant regulations.

Patients' individual needs, including social and emotional considerations, were included in their assessments. The premises were accessible for those with limited mobility and all services were provided on the ground floor. There was timely access to appointments once requested. There was a complaints process and we saw complaints were investigated and responded to.

Are services well-led?
We found that this service was providing well-led care in accordance with the relevant regulations.

There was a clear ethos of patient centred care. Governance arrangements were in place and enabled the day to day running of the service and identified where improvements may be required to the quality of the service. Patient feedback was encouraged and considered in the running of the service.

Oxford ADHD Centre

Detailed findings

Background to this inspection

We inspected Oxford ADHD Centre on 7 November 2017. A psychotherapist specialist adviser and a lead inspector undertook the inspection.

Pre-inspection information was gathered and reviewed before the inspection. This included staff roles and recruitment checks. We spoke with sub-contracted staff who worked for the service including a clinician. We spoke with the registered manager. We looked at records related to patient assessments and the provision of care and treatment. We also reviewed documentation related to the management of the service. We reviewed patient feedback sent directly to us and feedback received by the centre.

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.

Are services safe?

Our findings

Safety systems and processes

The service had clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The centre ensured that all clinicians and staff had completed safeguarding vulnerable adults and children training to suitable levels (level three child safeguarding training for all staff who provided care to children). We saw an example where the local safeguarding hub was contacted due to a potential disclosure from a patient. This occurrence was used as part of a significant event analysis to review safeguarding processes. There were child friendly notices in the consultation rooms which explained clearly that although what was said in rooms was confidential there may be times if the patient was at risk of harm that the staff may need to speak to external professionals.
- There were always two clinicians during patient assessments. All the staff who worked at the centre had Disclosure and Barring Service (DBS) checks (DBS checks provide background information on whether a person has committed a crime or is barred from caring for vulnerable adults or children).
- There was a log of recruitment and staff checks held by the provider. This indicated that all recruitment checks had been undertaken prior to employment. The provider's recruitment policy clearly stated that checks required included: proof of identity, two references, proof of qualifications, registration with the appropriate professional body and the appropriate checks through the disclosure and barring service (DBS). To verify the logs' accuracy we looked at one full set of records for a member of sub-contracted staff and saw that all the checks stated as checked in the log had been reviewed. We checked DBS checks for two members of staff.
- Qualifications of all clinicians were checked and revalidation dates for all these staff were also kept on the recruitment log.

Risks to patients

Most risks to patients were assessed and managed. However, there was not a full assessment of the potential medical emergency procedures which may be required:

- The provider checked the professional indemnity of their clinical professionals.
- There was a plan for emergencies which may occur and affect the running of the service. This plan was available to staff.
- The provider informed us that staff had first aid and basic resuscitation training (CPR) training. There were no physical treatment procedures or administration of medicines undertaken onsite. Therefore the risk of medical emergencies was minimal. However, there was no overall assessment of what emergencies may occur onsite and how the centre should respond. For example, there was no identification of whether an automatic external defibrillator (AED) was potentially accessible to the centre in a timely manner if required or an assessment of what equipment, medicines or planned actions may be required in any other medical emergency. An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electric shock to attempt to restore a normal heart rhythm in an emergency. After the inspection the centre identified that the neighbouring dentist had an AED and their staff were trained. This was not supported by a broader process for what staff should do in a medical emergency.

Information to deliver safe care and treatment

Patient records were stored securely using an electronic record system. Correspondence was shared with external professionals in a way that ensured data was protected. Information required passwords in order to access any data shared with external providers.

Risks related to patients' diagnoses and other health and wellbeing risks were recorded in patients' records. There were alerts on the system where staff needed to be made aware of any risks for their consideration.

Safe and appropriate use of medicines

Are services safe?

The provider prescribed medicines for the treatment of Attention Deficit Hyperactivity Disorder (ADHD). Two of the medicines were stimulants and were controlled drugs (medicines which require additional procedures to other medicines in storage and prescribing). No medicines were stored onsite.

The prescribing procedures included medical checks and observations prior to starting any medicines. Once patients were prescribed a medicine the centre informed GP practices and the centre undertook a period of assessment of the patient until the prescribing could be passed onto a GP practice. Patients were required to attend a periodic check with the service, without which the centre would not prescribe further medicines. We looked at an assessment which included proposed prescribing of medicines and alongside this, a clear plan of what ongoing checks were required to ensure safe prescribing for the initial months of taking the medicines.

A significant event had been recorded in October 2017 and was shared by the service with the CQC inspection team. This had identified that a patient may have provided incorrect details about their GP practice and therefore the patient received a prescription without relevant information being shared with or obtained from their GP. The centre identified this was a gap in their prescribing process and were considering what action to take in order to prevent a reoccurrence. The patient's prescribing had been stopped until a consultation was held with them to review the situation. However, the prescribing process was not yet amended to ensure this did not take place again. The centre was considering only accepting private patients through GP referrals to prevent this from happening again.

Blank prescription forms were stored securely. An electronic copy of each prescription issued was stored on patient records.

Track record on safety

There were systems to identify, assess and mitigate risks. For example:

- The premises were clean and tidy. An infection control policy and supporting checks were in place.
- The building was well maintained and a comprehensive risk assessment was recorded for the building.
- There was a fire risk assessment and related actions. This included regular checking of fire safety equipment including lighting and firefighting equipment.
- Electrical equipment was checked regularly to ensure it was safe. A log indicated that any equipment requiring calibration was calibrated annually. There was an electrical installation certificate for the premises.
- The provider had an overarching health and safety policy.

Lessons learned and improvements made

There was a process for recording and investigating incidents and events which may indicate required changes to practice and procedure. A significant event reporting tool was available and we saw examples where safety incidents had been recorded and investigations included a detailed review of what took place, what went well and what could have been done better. This analysis was used to identify learning outcomes. For example, when incorrect referral papers were received from an external provider the centre raised a significant event. The analysis reviewed what action had been taken and what may be done in future. Learning from such events was shared with relevant staff.

Are services effective?

(for example, treatment is effective)

Our findings

Identify a system to monitor the ongoing training of staff who provide services to patients, in order to ensure they have the skills and knowledge required to provide care safely and effectively.

Effective needs assessment, care and treatment

The service assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The service used a broad section of assessment techniques for both adults and children including life history accounts, social accounts from family, cognitive assessments and various tools used for assessing Attention Deficit Hyperactivity Disorder (ADHD) and autism. These included Connors assessments which help clinicians gain a full understanding of behaviours and habits as part of identifying any diagnosis.
- Specifically, children's assessments included information from school and home via interviews and other techniques. Parents or carers were also central to the diagnosis process. Cognitive assessments were used to look for any specific learning difficulties. An Autism Diagnostic Observation Schedule (ADOS) assessment was also used when autism is suspected from initial information about a patient. This is an observational test to assess communication, social interaction and play which is adapted to the age of the child and a detailed developmental evaluation.
- The autism and ADHD assessments were tailored according to information on each patient prior to conducting diagnostic tests. The centre provided two appropriately experienced and qualified clinicians for ADHD assessments. The provider explained that the mix of assessment techniques and the use of two clinicians provided a broader evidence base for greater accuracy in diagnosis. This goes beyond the requirements in NICE guidance which states that diagnosis of ADHD should be made by a specialist psychiatrist, paediatrician or other appropriately qualified healthcare professional with training and expertise in the diagnosis of ADHD, but no requirement for two professionals.
- Where medicines are recommended as a treatment for ADHD, a nurse prescriber or qualified doctor with expertise in ADHD prescribing, takes the necessary observations for patients as part of the prescribing process.
- We reviewed two anonymised assessment reports where a diagnosis of autism and/or ADHD was made. We found that the assessments included clear information and recommendations for patients and external providers to consider. The outcomes of each assessment were clearly recorded and presented with explanations to make their meaning clear.

Monitoring care and treatment

The provider explained that due to booking clinicians for sessional work it was difficult to hold clinical team meetings. To improve the understanding and consistency across all of the clinical psychologists working at the centre, the provider undertook a workshop with their sessional clinicians to review diagnosis using ADOS assessments in complex cases. This enabled the various experiences to be shared among the clinicians and enable them and the centre to better monitor and improve diagnoses.

There was no specific clinical audit activity, but individual patients on prescribed medicines were monitored to identify the appropriateness of their medicines before the monitoring of their medicines was transferred to GPs. The centre monitored the number of NHS referrals which resulted in diagnoses. The provider informed us that due to feedback from the centre to NHS child and adolescent mental health services (CAMHs) resulting from this monitoring, there had been improved screening prior to referral. The rate of diagnosis had increased from 60% when patients were initially referred to the centre in 2016 to 90% with more recent patients.

The significant event process was a means of monitoring care outcomes. Any incidents or concerns identified through referral, assessment or treatment were assessed and lessons recorded.

Effective staffing

The provider had identified a broad range of therapists and other clinical professionals which they were able to request to provide assessments. There was a nurse prescriber with expertise in ADHD who provided medical observations and

Are services effective?

(for example, treatment is effective)

monitoring reviews of patients on ADHD medicines. All staff had proof of their qualifications checked prior to working for the centre. A log of their safeguarding training was also kept.

Training was provided in the assessment process for ADOS assessments. There was an additional workshop to provide training on these assessments by the provider in November 2017. The registered manager was a contributor to NICE guidance on ADHD assessment and care.

The provider did not identify the full range of training which may be required periodically, although where staff provided proof of their ongoing professional development this was monitored. For example, 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). Following the inspection the provider assured us they had contacted each of their clinicians to obtain confirmation of when these areas of training had last been undertaken.

The provider had guidance within policies which it required all sub-contracted clinicians to read and refer to as a condition of their contracts.

Coordinating patient care and information sharing

We reviewed the system for sending and receiving patient correspondence. We found that letters were sent to GPs, CAMHs, parents, schools and other services where necessary explaining outcomes of assessments and proposed treatments or suggested support strategies. Correspondence was only sent with the full consent of patients. Correspondence received was reviewed and recorded on patient notes.

Supporting patients to live healthier lives

If a diagnosis of ADHD is made, a full explanation was given and advice regarding further management. For NHS and private patients a report was sent to parents or guardians, for review, then onto schools and relevant healthcare services with recommendations to provide support and strategies to help manage patients' symptoms.

For private patients treatments can be initiated at the centre. These include workshops for parents in helping children manage ADHD and autism, techniques for patients to help manage ADHD and autism themselves and prescribing medicines for ADHD.

Consent to care and treatment

Patients or where appropriate parents and guardians, were consulted regarding consent to assessment, treatment and sharing of information. For example, a concern identified about a patient was considered for reporting externally to an appropriate body. The criteria for deciding upon the referral included an assessment of a patient's ability to consent due to their age and whether it was in their interest for the referral to be made. There was supporting guidance regarding the MCA 2005 and on the Gillick competency in the provider's policies.

The service displayed full, clear and detailed information about the cost of assessments on their website.

Are services caring?

Our findings

Kindness, respect and compassion

The centre primarily worked with children. The provider explained that many children were nervous when attending and they had to work with parents to explain what was happening and any diagnoses compassionately.

The provider explained that families had an explanation of the assessment process together to help put families at ease. When children needed to be assessed without their parents present, the feedback given to the service and CQC suggested children were put at ease and even enjoyed many aspects of the assessment (much of which was play focussed).

We received 10 patient comments directly prior to the inspection via the CQC 'share your experience' portal on our website and three comment cards filled out by parents who had attended the service. All of the feedback we received from parents or patients was positive regarding the services. Feedback was particularly positive regarding the caring and kind nature of staff, at a time of stress and difficulty for parents and patients.

Involvement in decisions about care and treatment

Feedback suggested that patients or parents felt diagnosis and therapy options or treatments were explained clearly to them. The centre staff determined by the age of children, and other determinants about their emotional wellbeing, whether to include children in discussions around diagnosis or to enable parents to do this at a later date.

There was patient information literature which contained information for patients and relatives including treatment information. This included the strengths and limitations of the different types of treatment. We saw that treatment plans were personalised and patient specific which indicated patient and their relatives were involved in decisions about care and treatment.

Privacy and Dignity

The centre had consulting rooms with dense doors which reduced the risk of conversations being heard from outside. Electronic records were kept which protected patient data. Staff were required to read the confidentiality policy and statement regarding patient information was included in their contracts.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Due to each assessment process being individual to the patient, the centre responded to individuals' needs based on their own family, professional / school and social life. Emotional considerations and personal preferences were considered as key to determining the best holistic care planning for patients. For example, the patient assessments we reviewed recommended:

- How to support the patient with their school life in order to enable as much routine school time alongside their support structures.
- Self-directed learning around ADHD and autism for adults to help them understand their condition in order to provide their support strategies wherever possible.

The premises were carefully planned around the need to be unoppressive, particularly in consideration of the children who attend for assessments. For example:

- The centre waiting area was bright and uncluttered.
- Information in various formats was available about ADHD and autism in the waiting area.
- Child friendly posters were on the walls of consultation rooms. These included ChildLine contact details and child friendly confidentiality posters which clearly explained to children that what they said in the room was confidential unless they or someone else was at risk of harm.

The premises were accessible for those limited mobility and all services were provided on the ground floor.

Timely access to the service

The provider aimed to provide an appointment for their patients to undertake an assessment as soon as possible and informed us that assessments were usually undertaken within weeks of any request. Patients were offered various appointment dates to help them arrange for suitable times to attend. Autism and ADHD assessments, as well as new and follow-up appointments were undertaken on Saturdays for patients who had significant difficulty attending during the week.

The provider informed us that they were aware those patients being referred from child and adolescent mental health services (CAMHs) had usually waited for several months for an assessment prior to their referral. Therefore they tried to ensure that these patients were seen within weeks of their referrals.

Patient feedback we received confirmed they had flexibility and choice to arrange appointments in line with other commitments. Patients also commented that they were offered cancellation appointments if these were available.

Listening and learning from concerns and complaints

The provider had a complaints policy which set out the process for dealing with complaints. This included:

- Investigation of any complaint would take place.
- That a response would be made within 28 days.

We looked at a complaint received by the centre. The provider reviewed the records related to the assessment process in question and investigated the concerns. A response was made including reference to each of the elements of the complaint and an outcome for the patient. Only two complaints had been received since the centre opened.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Our findings

Leadership capacity and capability;

The provider had the experience, capacity and capability to run the service and ensure patients accessing centre received high quality assessment and care. It was evident through discussions with sub-contracted staff the service prioritised compassionate care. A sessional clinician we spoke with told us the provider communicated well with staff and ensured they were supported to undertake their roles.

Vision and strategy

The centre provided services to patients with an ethos of providing individualised care and treatment, considering and respecting the wishes of its patients and their families. The provider's strategy was developing and had continued to evolve since the service's inception in February 2016. They had responded to meet the evolving needs identified since they opened, specifically enabling NHS patients to access assessments. Where the provider identified that they required additional managerial and administration support they brought in appropriately qualified expertise to help them develop and run the service.

Culture

The reporting of concerns and investigation into complaints showed openness and honesty. This indicated that the provider paid due diligence to the duty of candour in the way they operated their services.

Governance arrangements

The service had a governance framework which supported the delivery of the strategy and good quality care. Service specific policies and procedures were in place and accessible to staff. These included guidance about confidentiality, record keeping, incident reporting and data protection. There was a process in place to ensure that all policies and procedures were kept up to date.

Managing risks, issues and performance

The service identified, assessed and managed clinical and environmental risks related to the service provided. We saw risk assessments and the control measures in place to manage those risks. All the risk assessments had identified risks and how to mitigate risks. However, there were risks associated with prescribing which had been identified, assessed but not yet mitigated via a change of prescribing process.

Appropriate and accurate information

Patient assessments, treatments and medications, including ongoing reviews of their care, were recorded on a secure electronic system. We reviewed two anonymised assessment reports where a diagnosis of autism and/or ADHD was made. We found that the assessments included clear information and recommendations. The clinical staff responsible for monitoring patients' care were able to access this information.

The provider had supporting documents regarding data storage from information commissioners office (ICO) and had protocols for safe sharing and storage of sensitive information. The provider was also registered with the ICO.

Engagement with patients, the public, staff and external partners

The service encouraged and valued feedback from patients and their families. They acted to improve services on the basis of this feedback.

- Comments and feedback were encouraged. These were reviewed and considered by the provider including negative comments.
- The service reviewed the feedback from patients who had cause to complain. A system was in place to assess and analyse complaints and then learn from them if relevant, acting on feedback when appropriate.
- There were many examples of compliments received by the service. For example, we saw several compliments relating to the caring nature of staff and the clear explanations around the assessment process and outcomes.

Continuous improvement and innovation

There were systems to identify learning outcomes and implement improvements where necessary.

- Patient feedback regarding a parenting workshop held at the centre to support patients with ADHD and autism, identified concerns about the format of a workshop and also the structure. This led to a review of the workshops

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

with the relevant sub-contractor on time keeping and also led to pre-workshop questions for those attending about their expectations so the workshops could be better managed.

- To improve the understanding and consistency across all of the clinical psychologists working at the centre, the provider undertook a workshop with their sessional clinicians to review diagnosis using Autism Diagnostic Observation Schedule (ADOS) assessments particularly in complex cases. This enabled the various experiences to be shared among the clinicians and enable them and the centre to better monitor and improve diagnoses.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment **How the regulation was not being met:** The registered person did not always assess the risks to the health and safety of service users receiving care and treatment in order to take any required action to mitigate such risks. For example: · The system for prescribing medicines did not ensure identification of patients or that medicines were appropriate to issue prior to prescribing · There was not an assessment to identify and manage which medical emergencies were reasonable to anticipate and prepare for. This was in breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.