Learning Assessment and Neurocare Centre Limited

LANCuk Heywood

Inspection report

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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	Inadequate
Are services safe?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

LANCuk (Learning Assessment and Neurocare Centre) provides assessment and treatment for both children and adults for attention deficit hyperactivity disorder (ADHD) and autism.

At the last inspection, we imposed conditions on the provider for failing to comply with Regulation 12 Safe Care and Treatment and Regulation 17 Good Governance. We found during this inspection that insufficient improvements had been made.

However, oversight of the prescribing process had improved by arranging for all prescriptions to be sent to nominated pharmacies rather than the individual patient, to reduce risk of the prescriptions going missing and there was oversight of the prescription numbers too.

Staff records now included health screening.

Our rating of this location stayed the same. We rated it as inadequate because:

- The service had not made significant improvements to the oversight of the prescribing of medicines. The service still did not have robust systems and processes in place for managing prescriptions and monitoring patients prior to repeat prescribing.
- Records were not complete and contemporaneous.
- Staff files had gaps, including gaps in work history and supervision.
- The registered manager had been absent from work since 6 January 2022, the interim manager had applied to be the registered manager, however, withdrew their application on 18 October 2022 following their interview. This meant there is not a registered manager providing leadership at the service and the interim arrangements did not include oversight of patients treated under a private arrangement.
- There were four mandatory training course with compliance levels below 70%.

However:

- Staff files now had health screening in place.
- Prescriptions were now sent directly to the pharmacies to reduce the risk of missed and lost prescriptions.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community mental health services for people with a learning disability or autism	Inadequate 	

Summary of findings

Contents

Summary of this inspection

Background to LANCuk Heywood

LANCuk (Learning Assessment and Neurocare Centre) provides assessment and treatment for both children and adults for attention deficit hyperactivity disorder and autism. Most of the staff working for LANCuk were self-employed on a sessional basis. The majority of staff had other substantive roles, mostly within NHS trusts.

LANCuk employed the director, one psychological wellbeing practitioner, one mental health nurse, one general nurse and health visitor, the clinical lead, the interim service manager, administration service manager, office manager and six administrators full time. LANCuk has been registered with CQC since 19 October 2017 to provide the following regulated activities:

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

The service accepts private referrals for children and adults and is commissioned by the NHS to provide assessments and diagnostics for adults living in Oldham, Rochdale and Bury.

The service had the following additional NHS funded contracts:

- Assessments for autism for children in Stockport.
- Assessments for attention deficit hyperactivity disorder for children in Tameside and Glossop.

The base in Heywood is where all the NHS patients are seen. LANCuk rent facilities in Wilmslow and London for their private patients. All administration takes place from the Heywood base.

The registered manager had been absent from work and the interim service manager had been covering for the registered manager responsibilities whilst applying to be the registered manager.

We last inspected the service in March 2022. The service was rated inadequate overall with ratings of inadequate for safe and well led. Following the inspection, we took urgent action and served a Notice of Decision which placed conditions on the providers registration. The Notice of Decision prevented them from accepting any new or repeat patients to the medicine prescribing service without the prior written agreement of the Care Quality Commission. We also instructed the provider to:

- implement an effective system for recording all future reviews of patients' prescription needs including details of clinical observations and decision making and minutes of prescription meetings by 26 April 2022
- review all treatment plans for all patients currently prescribed medicines and any patients who have been accepted for prescription service and awaiting their treatment to commence by 12 May 2022
- develop and implement an effective system for the oversight of dispensing prescriptions to ensure medicines are provided to patients securely and within the time period specified within treatment plans and complete an audit of the system on a monthly basis by 11 May 2022.

This service was placed in special measures in October 2021. Following a further inspection in March 2022 where we found insufficient improvements we took action in line with our enforcement procedures to begin the process of

Summary of this inspection

preventing the provider from operating the service. In this third inspection we found that insufficient improvements have been made such that there remains a rating of inadequate for a core service, key question or overall. Following concerns we served a Notice of Proposal, followed by a Notice of Decision to cancel the provider's registration. The service was deregistered on 13 February 2023.

What people who use the service say

Since the last inspection in March 2022, we received information of concern from 19 patients about the service. Fourteen were in relation to the medicine prescribing process, three were in relation to waiting times, one was in relation to records and one in relation to staff attitude.

We spoke with a parent who was supporting their child to an appointment, we observed the clinician come into the waiting room to collect the patient. They did not introduce themselves or explain the process, they told the parent that they had to wait in the waiting room and could go and get a coffee, but did not say where or how long the appointment would be. This experience was the same as feedback we received from another parent regarding their experience. We raised this with the manager to address.

During the inspection process, we received feedback from a patient and a family member regarding the prescribing process and the impact this had on their mood and ability to function, one patient felt so unwell that they may need to be admitted to hospital.

How we carried out this inspection

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

During the inspection visit, the inspection team:

- visited the service
- toured the service
- received feedback from commissioners
- spoke with one family member
- spoke with seven staff including administrators, non medical prescribers and service managers
- looked at eight care and treatment records of people
- looked at a range of policies, procedures and other documents relating to the running of the service including staff records and the repeat prescribing process.

This inspection was unannounced and was to follow up on the warning notices to see if the service had improved, and may be removed from special measures. The inspection focused on the safe and well led key questions.

The inspection team was a CQC inspector and a CQC medicines inspector.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Summary of this inspection

Areas for improvement

Following this inspection, we have not removed the conditions on the providers registration as the service has not met them fully.

Action the service MUST take is necessary to comply with its legal obligations. Action the service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services

Action the service MUST take to improve:

- The provider must ensure that clinicians record their activity with patients directly on the electronic care record. (Regulation 17)
- The provider must ensure that it meets the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Regulation 17)
- The provider must ensure they have robust systems and processes in place for managing prescriptions and monitoring patients prior to repeat prescribing. (Regulation 12)
- The provider must ensure they prescribe medicines safely. (Regulation 12)

Action the service SHOULD take to improve:

- The provider should develop a dress code policy.
- The provider should ensure minutes and records are accurate and include dates.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community mental health services for people with a learning disability or autism	Inadequate	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate
Overall	Inadequate	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate

Community mental health services for people with a learning disability or autism

Inadequate

Safe	Inadequate
Well-led	Inadequate

Is the service safe?

Inadequate

Our rating of safe stayed the same. We rated it as inadequate. Due to the enforcement action taken, the rating is limited to inadequate.

Safe and clean environment

All clinical premises where patients received care were clean, well equipped, well furnished, well maintained and fit for purpose.

The service was using five interview rooms and there was one administration office at the service.

Interview rooms did not have alarms for staff, however, substantive staff had the "green button" feature on their laptops which is a green button on the screen that staff can press if they need assistance. Since the last inspection, staff had been provided with panic alarms, portable devices that they could use to summon assistance.

All clinic rooms had the necessary equipment for patients to have thorough physical examinations. This included height measure and scales.

All areas were clean, well maintained, well furnished and fit for purpose. The landlord of the building coordinated the cleaning of the premises. Staff had access to antibacterial wipes to clean the equipment in-between use. There was one interview room that had been decorated to make it more welcoming for children, there were pictures on the wall of animated characters and toys and puzzles were in the room too.

Staff followed infection control guidelines, including handwashing. Staff had access to personal protective equipment (PPE), however staff no longer wore masks, in line with government guidance. We saw staff with nail varnish on this usually would not be allowed within a clinical setting, we requested the dress code policy and there was no one in place. This meant staff did not receive guidance on expectations of their dress code.

Staff made sure equipment was well maintained, clean and in working order.

Safe staffing

The service employed enough staff, who knew the patients and received basic training to keep them safe from avoidable harm.

The service employed one psychological wellbeing practitioner, one mental health nurse, one general nurse and health visitor, the clinical lead, the interim service manager, administration service manager, office manager and six administrators full time.

Community mental health services for people with a learning disability or autism

Inadequate

Seven mental health nurses, one speech and language therapists, two consultant psychiatrists and three life coaches were self-employed and worked a variety of hours for the service.

One of the consultant psychiatrists specialised in child and adolescent mental health and the other consultant psychiatrist specialised in adults. They were both available for support and guidance in between their clinics.

Mandatory training

Self employed staff completed their mandatory training with their substantive employers. The service requested evidence of completion of training which was stored on their staff file. Administrative staff accessed eLearning that was arranged by the service, since the last inspection, their training was now included in the training matrix.

The mandatory training programme included health and safety, infection control, conflict resolution, equality, diversity and human rights, information governance, Basic Life Support, Mental Capacity Act, Prevent, WRAP, safeguarding adults' levels 2 and 3 and safeguarding children levels 2 and 3. Recently included was autism and learning disability training to meet the requirements of the Health and Care Act 2022. We reviewed the training matrix and found there was one staff listed who was not included in the staff list. This meant the service did not have full oversight of staff and training.

For clinicians, review of the training matrix showed four courses with compliance below 70%; 59% for information governance, 65% for basic life support, 65% for resuscitation and 53% for safeguarding adults level 3. The matrix showed that managers had monitored mandatory training and had alerted staff when they needed to update their training or provide evidence of completion.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They responded promptly to sudden deterioration in a patient's health. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff did not follow good personal safety protocols.

Assessment of patient risk

Staff considered risk for each patient at appointments. We reviewed four care records, specifically to focus on risk and found that each record considered risk.

Staff did not use a recognised risk assessment tool, however there were templates available for the different types of appointments which included a heading on risk for clinicians to consider.

Management of patient risk

Staff monitored patients on waiting lists for changes in their level of risk and responded when risk increased. The service had a one page resource document which was sent out to all new referrals. This document explained the approximate waiting time for the service. The leaflet also provided information about where patients could go for support whilst they were waiting.

The service had a member of staff allocated every day to provide welfare calls if a patient was identified as requiring this. However, in one record we reviewed, we found that a welfare call was not requested promptly, and the concerned family member rang several time prior to the request being made.

Staff did not follow clear personal safety protocols, including for lone working. Since the last inspection, staff had been provided with panic alarms, which they took into appointments with them to summon assistance if required. However, the lone worker policy reviewed in March 2022 was a brief one page document and did not include what action staff should take if they were concerned for their own personal safety during an appointment.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff shared their training compliance from their substantive employer, this included safeguarding adults' level 3 and safeguarding children level 3. Staff received training on how to recognise and report abuse, appropriate for their role. This met the requirements of the intercollegiate document safeguarding children and young people: roles and competences for health care staff and adult safeguarding: roles and competencies for health care staff.

Staff did not keep up-to-date with their safeguarding training. Compliance levels for safeguarding adults was 53% and safeguarding children level 3 was 76%.This meant clinicians were not up to date with safeguarding adults training.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had not had any safeguarding concerns or submitted any alerts since the last inspection.

Staff access to essential information

Staff did not keep detailed records of patients' care and treatment. Records were not clear and up-to-date. However, they were now easily available to all staff providing care.

Patient notes were not comprehensive. The service used two systems for patient records. The electronic patient record which included patient contact details and appointments and a shared drive with folders for each patient. Since the last inspection, all clinicians now had access to the electronic record system, the action plan following the inspection stated that clinicians would add the summary of their appointments directly on the electronic record system. However, we reviewed eight care records and only one had an entry from a clinician which was a summary of the appointment. Clinicians continued to type their summaries and email them to the administrators to format and send to the GP, patient and add to the system.

We reviewed eight records. We found six incomplete records with no evidence of how or who cancelled a patient appointment, missing GP letters, clinic consultations, requests to change doses of medicines, observations missing including body mass index and action taken and outcome following a complaint regarding change in dose and delayed prescription was not recorded. This did not meet the records management code of practice or the requirements for individual professional bodies.

Although we were told that clinicians had had training in how to access the electronic record system, and the interim manager believed that clinicians were adding directly to the system, records we reviewed showed this was not happening.

Administration meeting minutes showed that there were gaps in activities on the electronic record system that they were reminding staff to complete.

Community mental health services for people with a learning disability or autism

Inadequate

Medicines management

The service did not use systems and processes to safely prescribe, administer, record and store medicines. Staff did not regularly review the effects of medicines on each patient's mental and physical health.

Medicines were prescribed by appropriately qualified staff. One member of staff was responsible for signing repeat prescriptions, which sometimes led to prescriptions not being sent out to the patient's nominated pharmacy in a timely manner. The service now only sent prescriptions out to the pharmacy rather than to the patient's home; this change had reduced the number of missing prescriptions and is an improvement since the last inspection.

Processes for managing repeat prescriptions were not robust. One member of staff updated a spreadsheet, which included when a repeat prescription was due and any clinical observations that had been requested. We found the information in relation to clinical observations such as weight and blood pressure were not always correct. We still found prescriptions did not always get to people in a timely manner as the date the service signed the prescription was late, which may have resulted in people missing their medication.

Prescriptions were not always copied to patients' records for future reference. Prescription stationery was stored securely and although the clinic now had a record of what prescription pads were kept at the location, the prescription numbers were not always recorded accurately. This meant the system to account for prescriptions was not consistent so there was a risk that prescriptions might go missing.

The service still had three different systems where care records were recorded, which included an email account. This meant that records were not always contemporaneous and chronological as they were not accessible in one system, which made it difficult for staff to support the delivery of safe and effective care. It was also not always clear which member of staff had made care records as staff did not have individual logins.

Track record on safety

The service did not have a good track record on safety.

Reporting incidents and learning from when things go wrong

The service did not manage patient safety incidents well. Staff did not recognise incidents and report them appropriately. Managers did not fully investigate incidents and share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff did not know what incidents to report and how to report them. The incident reporting policy, last reviewed March 2022 stated that staff received training in incident reporting, however training records did not include training on incident reporting.

Managers did not investigate incidents thoroughly. There had been three incidents since the last inspection in March 2022. One related to prescribers prescribing medicine for physical health needs, the action and outcome was the manager emailing all prescribers. There was no recorded outcome for an investigation to ascertain if this did occur and the contributory factors. There was another incident where a patient was prescribed the wrong dose of medicines, there was no evidence of an investigation completed or identified shared learning.

Community mental health services for people with a learning disability or autism

Inadequate

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Review of the incident database showed managers rang patients to apologise following a breach of information sharing however this was not shared with clinical staff. There was also a letter to a complainant with the investigation findings, minutes showed this was shared at the senior managers meeting in September 2022, however, was not shared with clinicians.

Staff at the senior managers meeting and clinical staff did not received feedback from investigation of incidents. We reviewed the minutes of meetings from the last six months and there was nothing shared regarding incidents.

Is the service well-led?

Inadequate

Our rating of well-led stayed the same. We rated it as inadequate. Due to the enforcement action taken, the rating is limited to inadequate.

Leadership

Leaders had the skills and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Leaders provided clinical leadership. The registered manager had been absent from work since January 2022, since the last inspection in March 2022, the interim service manager provided day to day oversight and management in the absence of the registered manager. The interim service manager had applied to be the registered manager, however decided to withdraw their application following the interview and identified further areas of knowledge they needed to develop including the legal requirements and expectations of CQC to submit notifications. They were in the process of resubmitting their application. They were one of the non-medical prescribers and provided clinics as well as leadership.

Leaders had the skills and experience to perform their roles. The interim service manager had been a manager prior to joining LANCuk. They were a non medical prescriber and qualified to complete autism assessments. However, their experience was mainly in the NHS and there were elements of leadership of an independent organisation that were new to them, including knowledge of the regulations and their requirements to meet them.

Leaders had a good understanding of the services they managed. They had continued to transfer patients over to their GP for prescribing under shared care, this meant there was less prescriptions being written by the service each month and the risk of errors reduced.

Leaders were visible in the service and approachable for patients and staff. The interim service manager was based at the office and provided clinics from there. Staff told us they were approachable and supportive.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Staff knew and understood the vision and values of the team and organisation and what their role was in achieving that. The ethos of LANCuk was "to consider that it has a responsibility in increasing factual professional and public awareness of neurobiological conditions such as ADHD 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 were passionate about raising awareness of autism and attention deficit hyperactivity disorder, the challenges of living with the condition and how people have developed strategies to live with the condition.

Staff did not have an opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Since the last inspection the meetings that took place were multidisciplinary meetings to discuss patients, monthly senior management team meetings and administration meetings. Strategy was not discussed within these meetings. This meant the development of the service had not been discussed with staff.

Staff could explain how they were working to deliver high quality care within the budgets available. Each of the administrators had been given a different responsibility, including the responsibility to oversee the booking of new referrals and coordinating the appointments process. Five permanent clinicians were employed by the service, which was an increase from the last inspection, to provide regular clinic availability, this meant there was guaranteed availability of clinics.

Culture

Staff felt respected, supported and valued. They could raise any concerns without fear.

Staff felt respected, supported and valued. The interim service manager was present in the service and approachable, we saw staff going to them for advice and guidance. There was a whistleblowing policy in place which included the opportunity for staff to raise concerns with CQC if needed.

Staff acknowledged the impact of service pressures and competing demands of the service, with receiving significantly higher numbers of referrals each month than they were contracted for.

Staff felt positive and proud about working for the provider and their team. Staff were positive about their roles, the opportunities to focus on autism and attention deficit hyperactivity disorder assessments and make a positive difference to patients' lives. Staff had been supported to do additional training including non medical prescriber training.

We reviewed four staff files and found that three staff had had an appraisals, this was an improvement since the last inspection.

The service had not had any bullying and harassment cases.

Staff did not have access to support for their own physical and emotional health needs through an occupational health service. However, managers told us they were getting quotes for possible providers. The provider had introduced a health screening form which all staff had completed in the files we reviewed.

The service had started to monitor morale, job satisfaction and sense of empowerment, since the last inspection there had been two staff surveys, one in May and one in November 2022. Areas for improvement were more training, more team meetings, current policies, improved facilities, opportunities for support for mental wellbeing and improved structure and communication.

The team worked well together however, there had only been two team meetings since the last inspection. All clinical meetings focused on patient reviews. This meant staff were not given regular opportunity as a team to discuss the service, receive feedback from incidents and complaints and updates about the service.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that performance and risk were not managed well.

Governance policies, procedures and protocols were not improved and did not include an equality impact assessment. The prescriber procedures dated November 2021, did not include what clinicians should do in relation to review of observations. It said, "Once observations are received from patient, clinic letter is checked, and patient added to the regular weekly prescription list". There was no guidance for where the decision should be recorded and what to do if the observations required further action. This could lead to the service continuing to prescribe for patients when it is not clinically appropriate to do so. The procedures had not been updated following the last inspection and continued to include contracts that were not being provided.

The medication and prescription policy dated December 2021 referred to doctors prescribing, the majority of the prescribing was completed by non medical prescribers. The information for patients regarding obtaining prescriptions procedure had not been updated following the change in practice that prescriptions were sent directly to pharmacies. The administration prescription process dated November 2021 had not been updated to reflect the changes in responsibility, there was one office manager who was responsible for supporting the prescribing processes. This meant the policy and procedure did not reflect the current practice.

There was no standard agenda for the administration meetings. There had been an agenda created for the senior management meetings which included service update, staffing issues, compliments, complaints, safeguarding and patients. However, there was no heading for incidents and any learning. Although there were some improvements, the service did not ensure that essential information, such as learning from incidents was shared and discussed.

There was no themes collated from incident reviews. Since the last inspection there had been three incidents, one involved the administration team, and this was not discussed at their team meetings. Another two incidents were related to prescribing and this was not discussed at the prescribers meeting. This meant learning from incidents was not shared with staff to avoid a reoccurrence.

Complaints continued to be investigated, with a system in place showing which were closed, in progress or required follow up. Changes took place following complaints including changing the content of standard letters explaining to patients what to expect with the service.

Following the last inspection in March 2022, there had been an audit of the patients waiting for medicines to be prescribed and if there was a risk. There were 76 patients waiting to be prescribed medicines, all listed as no risk. The summary of patients presentation and risk was stored in individual patient appointment summaries and no notes were on the audit. This meant the evidence for decision making was not easily accessible and in one record.

We reviewed the screening meeting minutes and for two weeks the minutes were the same and had not been accurately recorded.

Community mental health services for people with a learning disability or autism

Inadequate

Staff had started to undertake local clinical audits since the last inspection. These included audits of length of time to answer the phone and recording activities and contact in clinical records. Although the audits were completed, there was no summary or conclusions. However, we saw the findings of the recording activities audit discussed in the administration meeting to try to improve the service.

Records were not consistent, staff listed on the organisational structure, staff list and training records were not consistent, with different staff on different lists. This meant there was no assurance that staff had completed the necessary training and support.

Staff records did not meet the requirements of Schedule 3 of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014. We reviewed four staff personnel files and found there were now health screening included in each record.

However, we found three records did not have a full work history, including gaps in their employment history. Two did not have a start date or contract or any one to one meetings.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

There was not a clear quality assurance management and performance framework in place that was integrated across all organisational policies and procedures. Policies and procedures had not been reviewed and updated following our inspection in March 2022.

Staff did not maintain the risk register. This had not been updated following the inspection in March 2022. This meat the risk register was not current and did not include risks identified following the last inspection.

The oversight of prescribing arrangements had improved slightly since the last inspection. Prescriptions were now sent directly to the pharmacy, which reduced the risk of prescriptions going missing. During the review of medicine records and processes we found prescriptions were issued late and the necessary observations were not recorded and reviewed for each patient prior to prescribing.

Information management

Staff did not collect and analyse data about outcomes and performance and did not engaged actively in local and national quality improvement activities.

The service did not use systems to collect data from facilities and directorates that were not over-burdensome for frontline staff. There was duplication of information. Administration staff who took phone calls from patients continued to add these to the electronic care record and copied the contact into the patient folder on the shared drive. However, following the last inspection, we expected the information to be stored in the electronic record only. Staff had received training in accessing the electronic care records, however this focused on seeing clinician's clinic lists and contact numbers for patients, not on how to add information to the electronic care record.

Community mental health services for people with a learning disability or autism

Inadequate

Staff did not have access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, did not work well and did not help to improve the quality of care. There was one log in to the electronic patient record which meant that certain tasks could not be completed simultaneously as they would not save. Also, all activity would show as being completed by the reception, which meant the records did not accurately reflect who completed the entry onto the system.

Information governance systems did not include confidentiality of patient records. There had been one incident of breached confidentiality since the last inspection, where information had been sent to the wrong patient. This was not discussed at the administration meeting and action was not taken to avoid a reoccurrence.

The interim service manager had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Reports were collated including performance data for submission to commissioners.

Staff made notifications to external bodies as needed. This included statutory notifications to the Care Quality Commission.

All information needed to deliver care was stored securely and available to staff. However, the patient folders were difficult to navigate with a variety of documents all in one folder, there was no naming convention, or sub folders apart from prescriptions. Staff were gradually storing patient information to the electronic care records. Patient information continued to be stored within email sub folders too which meant not all patient information was available to staff.

Engagement

Staff, patients and carers did not have access to up-to-date information about the work of the provider and the services they used. The website was out of date and referred to a school liaison officer. These were not in place at the time of the inspection. The service did not create bulletins and newsletters. The statement of purpose submitted as part of the inspection did not reflect all of the locations the service was delivered from.

Patients and carers had been given opportunities to give feedback on the service they received in the form of questionnaires, feedback forms. Results showed that the feedback forms were mainly positive about the service. Areas for improvement included appointments being cancelled. Questionnaire results were positive with people saying they were satisfied with the service.

Learning, continuous improvement and innovation

The organisation encourages creativity and innovation to ensure up to date evidence based practice is implemented and imbedded. Non medical prescriber minutes showed colleagues shared their experience of titration of medicines in other services.

The service did not assess quality and sustainability impact of changes including financial.

Three out of four staff files reviewed showed staff had had an appraisal.

The service did not have a staff award/recognition schemes.

The service did not have any students on placement.

Community mental health services for people with a learning disability or autism

Inadequate

Leaders of the service were not members of any local or national groups in relation to autism and attention deficit hyperactivity disorder and relied on colleagues to provide updates in best practice.