LANCuk Heywood

Quality Report

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

Ratings

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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

We are placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

We rated LANCuk as requires improvement because:

• The registered manager had not taken sufficient action to remedy the concerns we raised at the last inspection. Patient records were not current and there were many sessions where records had not been completed. The registered manager had not taken action in relation to the provision of alarms in the interview rooms, providing a height measure in the Heywood base nor advising patients how to complain about the service.

• Risk assessments were not completed for all patients. The registered manager did not have oversight of safeguarding alerts or concerns.

• Several improvements were at an early stage including the introduction of senior management team meetings, appraisals and supervision for staff.

• Policies did not reflect the nature of the service. Mandatory training was not identified in the training and development policy. The duty of candour policy did not fully reflect the regulation. The calibration of equipment had not been identified as a requirement.

• The registered manager had not been proactive in communicating with the CQC in relation to requests for information, submitting statutory notifications and meeting the regulations of displaying the rating.

However:

• Patients feedback about the service was positive. Patients told us staff were very helpful and respectful, they were given information about their treatment and understood this.

• Staff had a good understanding of patients' needs and respected their confidentiality.

Summary of findings

Contents

Requires improvement

LANCuk Heywood

Services we looked at: Outpatients

Summary of this inspection

Our inspection team

The team that inspected the service comprised one CQC inspector and a CQC assistant inspector.

Why we carried out this inspection

We inspected this service within six months of the last inspection report being published as we rated the service inadequate and wanted to see the progress the service had made and review the actions in relation to the warning notices.

This inspection was unannounced.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

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

During the inspection visit, the inspection team:

- Toured the facilities at Heywood;
- spoke with six patients who were using the service and one carer;
- spoke with the registered manager over the telephone;
- spoke with four other staff members; including a nurse specialist, a coach and administrative staff;
- reviewed the comments cards from patients;
- looked at six care and treatment records of patients:
- looked at a range of policies, procedures and other documents relating to the running of the service including minutes of meetings.

Information about 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 are self employed on a sessional basis, the majority of staff have other substantive roles, mostly within NHS trusts. LANCuk employ the director and two administration staff.

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 people living in Oldham, Rochdale and Bury.

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.

Summary of this inspection

There was a registered manager in post at the time of the inspection.

LANCuk has had one previous inspection in July 2018 where the service was rated as inadequate overall. With the safe and well led domains rated inadequate, effective domain as requires improvement and caring and responsive domains as good. We issued two warning notices, one for Regulation 17 Good Governance and one for Regulation 19 Fit and Proper Persons Employed. We issued a requirement notice for Regulation 18 Staffing.

Since the last inspection, the registered manager submitted evidence in relation to employing fit and proper persons and examples of entries in the patient records. This was following CQC issuing a section 64 letter, where providers must respond within a set timescale.

What people who use the service say

We spoke with six patients, one carer and reviewed the completed feedback forms from the service's comments box.

Patients told us staff were very helpful and respectful,they were given information about their treatment and understood this. Patients were encouraged to involve family and loved ones in their appointments, which they found helpful as more people understood the information and family could contribute to the assessment process.

None of the patients we spoke with were aware of how to complain about the service and had not been provided with any information in relation to this.

Patients reported it took a long time to access the service and the base in Heywood was difficult for some people to get to.

Within the comments box we reviewed 16 feedback forms, all were positive and reported the service had been very helpful to them and their family.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

• Risk was not routinely documented for all patients. We reviewed six care records and found that four care records did not have a risk assessment.

• There was no alarm system in the interview rooms, this was highlighted at the last inspection and no action had been taken to remedy this.

• There was no evidence of the scales and blood pressure machine being calibrated, staff were not aware of any arrangements in place. There was no height measure in the Heywood base.

• Mandatory training was not identified in the training and development policy. Training records were not in place for all staff.

• There were gaps in the records we reviewed of staff not completing summaries of phone calls and appointments. This meant that records were not complete.

However:

• Staff understood the duty of candour and their role in relation to this. The duty of candour policy had been updated since the last inspection and included the level of harm which met the duty of candour threshold.

• Staff we spoke with had a good understanding of safeguarding, what constituted a safeguarding concern and how to make a safeguarding alert. Records reviewed confirmed that 91% of staff that had submitted their training records had had training in safeguarding children or adults at risk.

• Since the last inspection, staff training records were kept.

Are services effective?

Good

We rated effective as good because:

• Staff followed national guidance in relation to diagnosing and prioritising young people for assessments and treatment.

• LANCuk had a variety of disciplines working for them to enable patients to have access to a range of assessments and interventions.

• Team meetings, multidisciplinary meetings and senior management meetings were taking place.

However:

Summary of this inspection

• There were no formal induction arrangements in place, therefore there was no assurance that staff were receiving the same information at the start of working with LANCuk.

• Records showed that only two out of 11 staff had received training in Mental Capacity Act.

Are services caring?

Good

We rated caring as good because:

• Patients feedback about the service was positive. Patients told us staff were very helpful and respectful, they were given information about their treatment and understood this.

• Staff had a good understanding of patients' needs and respected their confidentiality.

• Staff involved patients and those close to them in decisions about their care and treatment. Summaries and plans of care were tailored to the individual needs of patients.

• LANCuk sought feedback from patients by having a comments box in the waiting room and encouraged patients to give feedback.

However:

• Contact between clients and the coach outside of the sessions was not recorded in the care records.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

• Patients reported a gap of between three and six months between appointments.

• Patients were not informed about how to make a complaint to the service.

• Interview rooms did not have adequate soundproofing.

However:

• The service did prioritise appointments for young people aged 16 and 17, to ensure they had an appointment prior to adulthood.

• The service operated a cancellations book to ensure a high uptake of the available appointments.

• Appointments were available in the evening and at a weekend.

Are services well-led?

Inadequate

We rated well led as inadequate because:

Summary of this inspection

• The registered manager had not ensured that recommendations following the last inspection had been implemented. We had to request information using our legal powers in relation to the evidence of compliance with the warning notices as the registered manager had not submitted the information by the date requested.

• There was no oversight to ensure risk was assessed for patients and captured in records. Records were not complete and contemporaneous, there were several appointments and activities where there were no summaries in the records. The registered manager did not have oversight of the safeguarding alerts or concerns.

• Policies did not reflect the nature of the service, with reference to inpatient provision and boards of trustees.

• Staff were not receiving supervision and appraisal as indicated in the policy. The provider did not have full records in relation to fit and proper person requirements and training for all staff.

• The registered manager was not following the regulations in relation to displaying their previous CQC rating and the submission of statutory notifications. The proposed statement of purpose did not include all expected requirements of the regulations.

However:

• Some progress had been made since the last inspection, some staff records were in place, including training completed and any reasonable adjustments required.

• The registered manager had set up a research development group.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

LANCuk had a service user consent policy dated 30 November 2018 which referred to the Mental Capacity Act.

Two out of 11 staff records had evidence that staff had attended training in the Mental Capacity Act. The expectation was that staff would access the training via their substantive roles.

Staff worked within the principles of the Mental Capacity Act. Records confirmed for a young person with a suspected learning disability, whose understanding was impaired, that the doctor referred the patient to one of their colleagues for further assessment of their level of understanding.

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Outpatients

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

Are outpatients services safe?

Requires improvement

Safe and clean environment

The base at Heywood was rented. It was part of an office block. LANCuk rented three interview rooms, an office, toilets and a kitchen. Patients had to buzz to get into the building then wait in a waiting area outside of the corridor.

Staff collected patients from the waiting area when it was time for their appointment.

There was no alarm system in the interview rooms, this was highlighted at the last inspection and no action had been taken to remedy this. Staff tried to mitigate risks by doing joint appointments if patients presented a known risk.

The service did not have all the necessary and maintained equipment for staff to fulfil their role. There were weighing scales and a blood pressure machine available for staff to use. There was no height measure in the base, however staff told us that children and young people were only seen at the other venues, therefore there was a mobile measure available for staff to use. Staff told us a height measure was only needed for children and young people. The British National Formulary states that, "Pulse, blood pressure, psychiatric symptoms, appetite, weight and height should be recorded at initiation of therapy, following each dose adjustment, and at least every 6 months thereafter."

National Institute for Health and Care Excellence guidance, Attention deficit hyperactivity disorder: diagnosis and management [NG87] Published date: March 2018 states that for the baseline assessment, height and weight should be measured, including for adults. There was no evidence of the scales being calibrated and the blood pressure machine was new and staff were not aware of the arrangements to have this calibrated. Following the inspection, the registered manager confirmed they had made arrangements for the equipment to be calibrated.

The maintenance and cleanliness of the building was overseen by the building manager. We reviewed health and safety records for the building including fire, insurance and an environmental risk assessment, all were in date. The rooms were clean, well-furnished and well maintained.

Safe staffing

The majority of the staff working for LANCuk were self employed on a sessional basis, most staff had other substantive roles, mostly within NHS trusts. LANCuk employed the director and two administration staff. Staff working on a sessional basis consisted of four consultant psychiatrists, one consultant clinical psychologist, one consultant paediatrician, one speech and language therapist, a coach, three nurse practitioners and a lead for attention deficit hyperactivity disorder and a lead for autism. Staff provided their availability for work at least a month in advance to allow for appointments to be booked in.

The training and development policy, dated November 2018, did not specify which training was mandatory for staff. Staff were expected to access their training via their substantive employer which was usually an NHS trust.

Requires improvement

Outpatients

Eight out of 13 staff had submitted evidence of training they had completed. The registered manager advised that training considered to be mandatory was: Conflict Resolution, Equality, Diversity and Human Rights, Information Governance, Mental Capacity Act, Mental Health Act Code of Practice, Prevent WRAP, Safeguarding Children and Adults Level 3. The registered manager had started to complete training records for staff, with the names of staff, mandatory training and dates they had attended the training. Training that had been prioritised for staff to attend was safeguarding.

Assessing and managing risk to patients and staff

Staff did not routinely complete risk assessments for each patient. We reviewed six care records and found that four care records did not have a risk assessment. Two contained an assessment of risk, one came from the referring professional and the other was completed by the consultant psychiatrist following their assessment. We saw from information submitted by the provider that if staff had identified a specific concern regarding an individual's risk, they would email their fellow clinicians and the administration team, for that to be included on the electronic record system. Clinicians also highlighted concerns with the patient's GP for their follow up. We saw alerts could be added to the electronic system however; there were none identified in the records we reviewed.

There was a 'Summary of Risk Assessment of Patients' document in place, advising staff that, "At each appointment a proper evaluation of risk of harm to self or others is conducted." However, records did not confirm staff were doing this.

The service prioritised referrals for young people aged 16 and 17 to enable them to meet the National Institute for Health and Care Excellence guidance (NG87) in relation to transition.

Safeguarding

Staff attendance at safeguarding training had improved since the last inspection. Following the last inspection, we identified that staff had not had training in safeguarding children and adults at risk. Records reviewed confirmed that 91% of staff that had submitted their training records had had training in safeguarding children or adults at risk.

The designated safeguarding lead had completed safeguarding children level three and had safeguarding adults level three training booked for 30 January 2019.

LANCuk had a safeguarding policy dated 30 November 2018 which referred to the Care Act 2014 and PREVENT (Prevent works to stop individuals from getting involved or supporting terrorism or extremist activity.) Staff we spoke with had a good understanding of safeguarding, what constituted a safeguarding concern and how to make a safeguarding alert. Information submitted by the provider showed clinicians made a safeguarding referral to a patient's local authority in September 2018 and they informed the registered manager by email. However, when asked, the registered manager advised that they were not aware of any safeguarding concerns or alerts within the last 12 months.

Staff knew 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 arrangements for safe working practice included there being at least two staff in the building when patients were being seen, to allow for support for colleagues. We observed staff arranging their work commitments to ensure this could be achieved.

Staff access to essential information

Staff had access to electronic care records. Administration staff added appointments to the system and it showed if the appointment went ahead or not. There was a notes facility in the system which staff used to record phone calls and voicemails for cancelled sessions. We saw notes in use in two out of the six records we reviewed. Summaries of appointments were recorded in the form of a letter which was sent to the patient, their GP and stored in the attachments tab of the records.

Records were not up to date. Five out of the six records we reviewed had missing summaries of appointments or phone calls that had taken place. Patients had had appointments on 30 June 2017, 26 September, 19 and 22 November 2018 and as of the inspection there was no summary completed. When we explored this, staff told us that the sessions held in 2018 were due to staff sickness and annual leave, however there was no record on the system as to what happened in those sessions. This meant that if the patient contacted the service, staff

would not be able to access the content of the session or check that any actions had been followed up in a timely manner. There were three examples where telephone calls were made between staff and patients but the care records did not include what the call was regarding. This meant that information was not always accessible to other clinicians who may be working with those patients.

Medicines management

Staff at LANCuk prescribed medicines. The arrangements were that the prescription was written and scanned onto the electronic care record and the original given to the patient. There was a separate spreadsheet that recorded which patients LANCuk were prescribing for and when the next prescription was due. This was a safer system than when we last inspected, as previously they kept copies of the prescription in paper form in one file and now they were stored on patient's individual records.

Track record on safety

LANCuk had not had any serious incidents in the last 12 months.

The registered manager had started to hold senior management meetings which provided an opportunity to share updates regarding policies, procedures and incidents.

Reporting incidents and learning from when things go wrong

Staff knew where to access the policies and forms in relation to incidents. There had been no incidents in the last 12 months.

Staff understood the duty of candour and their role in relation to this. The duty of candour policy had been updated since the last inspection and included the level of harm which met the duty of candour threshold. However, the policy did not include that all findings must be given in writing to the affected party.

Are outpatients services effective?

Good

Assessment of needs and planning of care

The service provided by LANCuk was to complete an assessment and diagnose if a patient had autism or attention deficit hyperactivity disorder or another condition including attention deficit disorder. If appropriate, staff prescribed medication or referred people to the coaching service within LANCuk. Patients may only be seen on one occasion or several occasions. Staff used the Autism Diagnostic Observation Schedule which is a recognised method of diagnosing autism.

Once the decision regarding a diagnosis of autism had been made, the autism lead met with the patient and significant others to provide feedback.

Appointments with consultant psychiatrists, psychologists, nurses and speech and language therapists resulted in a detailed summary of the content of the session which was sent to the patients GP and the patient. These varied in format and areas explored, dependant on the clinician that met with the patient. Each summary ended with a plan for the patient which may include medicine, actions to GP and when they would be seen again.

If patients received support from the coaching service, they had a plan in place, a summary of the coaching session and the expectations of the patient. Some patients also had a timetable of their activities to assist with their actions.

Patient information was stored on an electronic record system. At the last inspection the prescriptions were stored in paper form, this had now changed and prescriptions were scanned in and stored in the individual patient record, which meant all information regarding a patient was stored in once place.

Best practice in treatment and care

Staff provided treatments and care for patients based on national guidance and best practice. Information regarding substance misuse issues was gathered at the assessment stage, prior to prescribing any medicine. There was a titration clinic in place, where patients discussed how their medicine was working, if any changes were needed and if they experienced any side effects. Shared care agreements were in place for GP's to continue the prescribing of medicine for patients in line with best practice guidance.

Staff used the Barkley Adult Attention Deficit Hyperactivity Disorder Rating Scale with patients to capture their current symptoms and used this as a comparison to previous sessions to monitor progress or deterioration.

The registered manager had completed an audit of patient records in October 2018, however there was no actions from the audit in relation to areas for improvement.

Skilled staff to deliver care

LANCuk had a variety of disciplines working for them including consultant psychiatrists, consultant clinical psychologist, consultant paediatrician, speech and language therapists, and a coach, nurse practitioners and a lead for attention deficit hyperactivity disorder and a lead for autism.

Following the last inspection, the registered manager submitted information to CQC in relation to the qualifications of staff working for LANCuk. References were in place for seven out of 13 clinicians. However, for the most recent clinician to join LANCuk, interview notes and all other information including references were in place.

Staff did not receive a formal induction, the registered manager told us the topics they covered included access to the portal for human resources and health and safety advice and the location of the policies. However; there were no documents relating to this or evidence that this had taken place.

Since the last inspection, senior management meetings were taking place. Administration team meetings and multidisciplinary meetings continued to take place.

We reviewed the minutes and found topics discussed included referrals, policies and the introduction of the titration clinic.

The supervision policy, dated 30 November 2018 advised monthly group meetings would be available for clinicians, which minutes confirmed were taking place in addition to annual meetings with the registered manager. Records confirmed 23% of staff had had a one to one meeting with the registered manager, however they advised the process had only started following the introduction of the new policy. Dates were booked in for the remaining staff. We reviewed the records and found six staff had had an appraisal. We reviewed the staff file for the most recent staff member which had all the requirements within it.

Staff had specialist training for their role. However, this was not provided by LANCuk. Records confirmed staff completing the assessments for autism had been trained in the Autism Diagnostic Observation Schedule. The coach had attended training in life coaching for people with attention deficit hyperactivity disorder and was a member of the international coach federation. A nurse specialist had a masters' degree in autism.

Multi-disciplinary and inter-agency team work

Staff from different disciplines worked together as a team to benefit patients.

Records confirmed and evidence submitted by the registered manager showed that staff passed onto each other and the administration team, the updates and actions regarding patients and any concerns that they had.

Monthly multidisciplinary meetings were taking place which provided an opportunity to discuss patients.

Information was shared after appointments with the summary that was sent to the GP. Records confirmed information was shared with children's services where appropriate.

Good practice in applying the Mental Capacity Act

LANCuk had a service user consent policy dated 30 November 2018 which referred to the Mental Capacity Act.

Two out of 11 staff records had evidence that staff had attended training in the Mental Capacity Act. The expectation was that staff would access the training via their substantive roles.

Staff worked within the principles of the Mental Capacity Act, records confirmed for a young person with a suspected learning disability, whose understanding was impaired, that the doctor referred the patient to one of their colleagues for further assessment of their level of understanding. Staff supported patients to make decisions on their care for themselves, in relation to treatment within the consultations and in relation to the aims and plans within the coaching sessions.

Requires improvement

Outpatients

Are outpatients services caring?

Good

Kindness, dignity, respect and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity, and supported their individual needs. We observed staff interacting with patients in a respectful and caring manner.

We spoke with six patients, one carer and reviewed the completed feedback forms from the service's comments box.

Patients told us staff were very helpful and respectful, they were given information about their treatment and understood this. Patients were encouraged to involve family and loved ones in their appointments, which they found helpful as more people understood the information, their condition and family and loved ones could contribute to the assessment process.

Staff had a good understanding of patients' needs and circumstances, when we clarified information from within records, staff had a good memory recall and could elaborate on patient's circumstances.

Staff respected patient's confidentiality, when taking phone calls, they ensured they were talking with the patient by asking for identifying information. Appointments lists were stored in locked drawers which staff accessed when patients arrived.

The involvement of people in the care that they receive

Staff involved patients and those close to them in decisions about their care and treatment.

Appointment summaries included a plan of care, which was tailored to the individual, with clear actions for the staff and patients that were goal focused. The coach completed a summary of the session, which was sent to the patient and included the coach's contact details. Patients reported calling the coach outside of the sessions for advice and support. The coach confirmed this however; they told us this was not documented. A planner was also created which included the actions that were agreed within the session. Patients reported involving their family in the coaching sessions was helpful too.

There was a comments box in the waiting area of the Heywood base, we reviewed the contents, there were 16 feedback forms. All were positive and reported the service had been very helpful to them and their family, examples included negotiating with their employers regarding reasonable adjustments and implementing strategies to manage their condition.

Are outpatients services responsive?

Requires improvement

Access and discharge

There were 285 NHS patients waiting for an appointment.

The oldest referrals dated back to April 2018. There were 23 people referred in April 2018, opt in letters were sent out on 30 October 2018. Once people had responded to say they wanted an appointment the administration team booked them in. At the time of the inspection, the next available appointment for NHS patients was 2 March 2019. This meant a wait of 11 months. Patients told us and the feedback forms confirmed that there was a long wait to access the service, patients reported between three and six months between appointments. Patients reported waiting over six months for their initial appointment. The registered manager advised that the two consultant psychiatrists for adults were finishing at the end of January 2019 which would have an impact on future appointments.

However, the service did prioritise young people aged 16 and 17 in line with best practice guidance. There was no waiting list for private patients.

The service operated a cancellations book, where people's details were stored and if a cancellation came in, patients were contacted to fill the appointments. We observed administration staff doing this during the inspection.

The patient guide/statement of purpose document described the nature of the service, skills and experience of the staff and treatments and services available.

Requires improvement

Outpatients

If patients did not attend appointments, the administration team wrote to them, advising of the process for another appointment. When further appointments were missed, the administration team wrote to patients to advise no further appointments would be made for them and they would be discharged.

Appointments were available mid-week, both in the day and evenings and at a weekend. Appointment availability was dependant on the clinician's availability.

On the day of the inspection, there was a coaching clinic and a medicine optimisation clinic. We observed appointments to run on time and administration staff were efficient when patients arrived of informing the clinician they were there.

The facilities promote recovery, comfort, dignity and confidentiality

The three interview rooms were welcoming and well furnished, with minimal items to reduce the stimulus for patients.

Interview rooms did not have adequate soundproofing, we could hear conversations in neighbouring rooms.

Information was available in the interview rooms for patients in relation to conditions, treatment options and support available. There was a resource file available to clinicians with details of the service, referrals processes and contact details for local areas in relation to social care, crisis and out of hours support.

Meeting the needs of all people who use the service

The service was based on the ground floor of the building.

The registered manager confirmed that interpreters were booked via an interpreter and translator service, which was convenient to the patient and interpreter.

Listening to and learning from concerns and complaints

Patients were not informed of how to complain to the service. Of the six patients we spoke with none knew how to complain about the service. There was no information on display in the waiting room or treatment rooms regarding how to complain. The registered manager confirmed they did not tell patients how to complain but they were in the process of developing a service user guide which would include how to complain.

The service had received one complaint in the last 12 months from a commissioner on behalf of a patient. The registered manager kept a log of complaints in accordance with the complaints policy dated 30 November 2018. The complaint received was investigated and a response sent to the complainant. Records confirmed the complaint was discussed in the senior managers meeting.

Are outpatients services well-led?

Inadequate

Leadership

Since the last inspection, the registered manager had met with the local clinical commissioning groups to discuss the inadequate rating and was working to achieving the actions agreed on the remedial action plan.

Although progress had been made since the last inspection, the provider had not ensured all elements of the warning notice had been met. Records continued not to be contemporaneous, staff records were now in place for some. Supervision and appraisals had not taken place with all staff.

Vision and strategy

The ethos of LANCuk was "To consider that it has a responsibility in increasing factual professional and public awareness of neurobiological conditions such as Attention Deficit Hyperactivity Disorder as part of the overall spectrum of mental health difficulties. It considers that it is important to emphasise the reality and real- life difficulties experienced by people with such untreated conditions and their impact on society generally."

Staff we spoke with were aware of this ethos and worked to deliver high quality care for patients.

The registered manager was also the director, staff knew who they were and had regular contact with them. Staff reported they visited the Heywood base on average on a weekly basis. Staff reported they were approachable and they communicated via phone and email.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Good governance

The governance arrangements were developing, however there was not a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish. The regulatory action requirements identified following the last inspection in relation to good governance had not been fully met.

Since the last inspection in July 2018, only 23% of staff had had a one to one meeting with the registered manager. The adult consultant psychiatrists advised they were finishing at the end of February 2019, which would leave no adult consultant psychiatrists to assess, review and prescribe treatment for patients. The registered manager advised they were networking with professionals to expand the workforce.

Mandatory training had not been identified in the Training and Development policy that was written on 20 November 2018, after our last inspection. The provider did not provide any training to staff, they were expected to source their own training. There was no formal arrangement in place for the induction of new staff. Records in relation to training and requirements in relation to fit and proper person requirements were not in place for all staff. The registered manager held details in relation to training for eight out of 13 clinicians.

We reviewed the policies and identified several were not relevant to the service, they related more to a trust or inpatient provision. For example, the service user consent policy, dated 30 November 2018 states, 'service users receiving elective treatment or investigations for which written consent is appropriate should be familiar with the contents of their consent form before they arrive for the actual procedure. …..pre admission clinic.'

The duty of candour policy dated 30 November 2018 did not include that all findings must be in writing. However, it now included the level of harm sustained to meet the threshold for duty of candour to apply. Staff we spoke with were not aware of the location of the incident reporting form which was referred to in the Duty of Candour policy.

Staff attendance at training in safeguarding had improved since the last inspection. However, the registered manager did not have oversight of the safeguarding alerts and concerns. There had been a safeguarding alert made in September 2018, when asked the registered manager advised there had been no alerts or concerns within the last 12 months.

Following the CQC's request for information, an example had been shared of safeguarding concerns passed to the local authority, including via their online referral form.

There are several statutory notifications that registered providers must submit to CQC, one is for abuse or allegations of abuse concerning a person who uses the service. There have been no CQQ notifications made by the provider to CQC.

The statement of purpose submitted did not meet the requirements of the (Registration) Regulations 2009. The document did not include the legal status of the provider, registered managers name, business address and where documentation should be sent and in which format.

Records were not up to date. Five out of the six records we reviewed had missing summaries of appointments or phone calls that had taken place. This is a continued breach in relation to keeping contemporaneous records.

The registered manager had not displayed the ratings from the last inspection at their office base or on the front page of their website, therefore members of the public and potential customers would not know what the ratings of the service were.

Contract reviews were held on a quarterly basis, the service key performance indicators were in relation to numbers of referrals, meeting the target of prioritising the referrals for young people aged 16 or 17 and the numbers of appointments where patients had not attended. The service reported this data to the commissioners of the service. Although a file audit had taken place, no action had been taken in relation to the findings.

Requires improvement

Outpatients

Management of risk, issues and performance

The service did not have effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. The risk register viewed on site was different from the one shared with us, staff did not have access to the most recent version of the risk register. The risk register had been reviewed since the last inspection, the current version included the risk rating, risk description and the current control measures and date for review. However, they did not include date for completion.

The registered manager had not taken any action in relation to the findings from the last inspection regarding oversight of risks. This included no alarm system in the interview rooms and staff not following policies in relation to assessing and managing risk.

Engagement

Patients were encouraged to provide comments in the comments box in reception, however this had not been emptied recently and there was no clear structure as to what would happen to the feedback given, where this would be reported and the action taken.

The registered manager did not advise patients how to complain about the service, this was highlighted at the last inspection and no action had been taken to remedy this.

Staff were encouraged to give their feedback at the multidisciplinary meetings and senior managers meetings. These meetings included the review of policies and procedures. Staff we spoke with were very positive about their role and the work of the organisation. We observed staff working well as a team and supporting each other.

There were no other ways of involving patients in the service and patients were not involved in the recruitment and selection of staff or the development of the service.

Commitment to quality improvement and innovation

The registered manager had set up a research development group in October 2018, there had been two meetings and the aim of the group was to use the data they collected in clinical practice to the benefit of patients. This group was still developing when we inspected.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

• The provider must ensure that mandatory training is identified, staff attend this and a record of staff's attendance at the training is kept.

• The provider must ensure there is a system in place for all assessments to include an assessment of risk of patients.

• The provider must ensure there are arrangements in place to have complete records for patients in a timely manner following patient contact.

• The provider must ensure policies reflect the service delivered and comply with the regulations including the duty of candour policy, service user consent policy and training and development policy.

• The provider must ensure there is oversight of the safeguarding concerns and alerts made.

• The provider must ensure patients are informed of how to complain about the service and this is displayed within the bases.

• The provider must ensure patients have timely access to the service in line with best practice guidance and develop a system of monitoring the people on the waiting list for increased risk.

• The provider must ensure there is a height measure in place at the Heywood base.

• The provider must ensure there are personal alarm arrangements for clinicians to use in the interview rooms.

• The provider must ensure they submit statutory notifications for specific incidents as specified in the Care Quality Commission (Registration) Regulations 2009 and that the statement of purpose meets the regulation and is submitted with a statutory notification.

• The provider must ensure there are induction arrangements in place to provide staff with consistent information, and records are kept of this.

Action the provider SHOULD take to improve

• The provider should ensure the calibration of equipment takes place.

• The provider should ensure that supervisions and appraisals take place with staff as stated within the policy.

• The provider should ensure that staff attend Mental Capacity Act training and that staff are aware of the Mental Capacity Act, and their role in relation to this.

• The provider should review the soundproofing of the rooms to ensure patients privacy, dignity and confidentiality are respected.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not have formalised risk assessments in place and this was not explored at referral or consistently at assessment stage. Interview rooms did not have alarms in them and there were no portable alarms in use. There was no height measure in the Heywood base, the British National Formulary recommends baseline measures including height prior to prescribing. These were noted in the last report and the provider had not taken any action in relation to this. This is a breach of 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Patients were not informed of how to complain to the service. Of the six patients we spoke with they did not know how to complain about the service. There was no information on display in the waiting room or treatment rooms regarding how to complain. This was noted in the last report and the provider had not taken any action in relation to this. This is a breach of 16 (2) 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. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance We have issued a warning notice in relation to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.