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 effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
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.

Following this 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.

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

- The service did not provide safe care. The service did not have oversight of the prescription management process to mitigate the possible misuse of prescriptions and ensure it was safe or appropriate to increase the dose of the medicine before prescribing or continuing to prescribe for patients when clinically appropriate to do so.
- The registered manager had not taken sufficient action to remedy the concerns we raised at the last inspection.
- Multidisciplinary meetings had not taken place and information had not been shared with clinicians. This meant staff were not given the opportunity as a team to discuss the service, receive feedback from incidents, complaints and updates about the service.
- There was no information provided to patients regarding the service including what to expect and timescales.
- Staff records did not include all required documentation and checks.
- The service was not well led, and the governance processes did not ensure that procedures relating to the work of the service ran smoothly. Staff did not engage in clinical audit to evaluate the quality of care they provided.

However:

- Clinical premises where patients were seen were safe and clean. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff provided a range of assessments and treatments that were informed by best-practice guidance and suitable to the needs of the patients.
- The service included or had access to the full range of specialists required to meet the needs of the patients. Managers ensured that these staff received training and supervision.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients, families and carers in care decisions.
- The service had introduced the oversight of incidents and complaints, with a database and clear investigations with records to support the decision making.

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

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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, service manager, psychological wellbeing practitioner, mental health nurse and 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 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 since January 2022, during this time the lead NHS Clinical Commissioning Group and associate Clinical Commissioning Groups devised a package of support and provided guidance to the service until the 25 March 2022. The service manager started in post on 14 February 2022 and was in the process of applying to be the registered manager.

We last inspected the service in October 2021. The service was rated inadequate overall with ratings of inadequate for safe and well led. As a result of this inspection, we used our enforcement powers to serve a Warning Notice to the provider under section 29 of the Health and Social Care Act 2008. This was served for failing to comply with Regulation 12 Safe Care and Treatment and Regulation 17 Good Governance. We placed the service into special measures. Services placed in special measures are inspected again within six months of the report being published. This inspection was to follow up on the progress made from that inspection.

We found during this inspection that insufficient improvements had been made and we used our enforcement powers to impose conditions on the provider under section 31 of the Health and Social Care Act 2008. These were imposed for failing to comply with Regulation 12 Safe Care and Treatment and Regulation 17 Good Governance. The provider remains in special measures.

Services placed in special measures are inspected again within six months of the report being published. The service remains in special measures.

What people who use the service say

Summary of this inspection

Since the last inspection in October 2021, we received information of concern from eight patients about the service. Five were in relation to the medicine prescribing process and three were in relation to the appointment and referral process.

We spoke with 11 patients and four family members during this inspection.

Patients were very positive about the coaching service and the person centredness of the service which was goal focused. Following diagnosis of ADHD, patients said the information provided was very helpful regarding their condition and medicines. Patients also said clinicians understood their condition, were knowledgeable and communicated with them in an accessible way.

Two patients we spoke with, experienced difficulties with the prescribing process which resulted in them being without medicines for two weeks until staff eventually dropped their prescription off for them.

Patients told us of challenges with getting through to the service on the phone, messages not being passed on and calls not returned. They also stated there were delays in receiving reports following appointments.

Patients also said that not having consistency of clinicians meant their appointments could be with different clinicians and they felt like they were explaining their story again. Patients said it would be helpful to know the timeframes and what to expect in between appointments and the content of the appointments, for example follow up appointments, to help with managing expectations. Also, if a patient scored high on a screening tool which may indicate another condition, they would like to be informed so that they could access support if needed.

One family member found the service really helpful and said they were provided with useful information. They told us that staff ensured their child was settled with treatment prior to them being discharged.

Three family members were disappointed with the waiting time to access the service and the logistics of travelling on public transport from another borough to the service was a concern to one family we spoke with. One family said it would be helpful to know what to expect with gaps in between appointments and if they had received the report from appointments in a timely manner rather than having to chase the service for it.

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 11 patients
- spoke with four family members
- observed two face to face appointments and a remote appointment
- spoke with eight staff including administrators, consultant psychiatrist, psychological wellbeing practitioner and service managers
- looked at 11 care and treatment records of people

Summary of this inspection

- 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 covered all key questions.

The inspection team was a CQC inspector, a CQC medicines inspector and a specialist advisor.

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.

Areas for improvement

Following this inspection, we took urgent action and served a Notice of Decision which placed conditions on the providers registration.

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 service must ensure medicines are prescribed safely. (12(1) (2) (g)
- The service must implement an effective system for the oversight of prescriptions. (17 (1) (2) (a))
- The service must ensure that they have current evidence of training completion for staff and this is recorded in the staff files. (17(1)(2)(d))
- The service must ensure that staff files included health screening and any reasonable adjustments required. (17(1)(2)(d))
- The service must ensure there is an accurate, complete and contemporaneous record in respect of each patient including contact made by the patient and summaries of appointments. (Regulation 17 (1) (2) (c))

Action the service SHOULD take to improve:

- The service should share the findings of investigations with patients.
- The service should ensure that the incident report policy reflects their process and ensure staff are aware of the policy and their role in following it.
- The service should ensure staff are aware of the personal safety arrangements for clinical appointments and review the lone worker policy to reflect this.
- The service should continue to develop and facilitate the training for clinicians on how to use and add to the electronic care record.
- The service should ensure that all staff access training in autism in preparation for the Oliver McGowan mandatory training.
- The service should ensure that staff are aware of the Mental Capacity Act policy and their role in relation to this.
- The service should ensure that information is available in different language for patients whose first language is not English and easy read information is available for patients.
- The service should ensure the complaints policy provided to patients, including via the email footer is the current version.

Summary of this inspection

- The service should develop information to provide to patients about what to expect from the service, approximate waiting times and include how to give feedback about the service including how to complain.
- The service should consider the waiting room and clinic rooms and how welcoming they are to children and young people.

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	Good	Good	Good	Inadequate	Inadequate
Overall	Inadequate	Good	Good	Good	Inadequate	Inadequate

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

Inadequate

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

Are Community mental health services for people with a learning disability or autism 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 had increased the number of interview rooms they had access to. 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. Staff demonstrated this during the inspection and found that staff took over a minute to respond, there was confusion about the process and locum staff did not have access to the green button. This meant there was not a consistent approach to manage staff's safety when staff required 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.

Staff followed infection control guidelines, including handwashing. Staff had access to personal protective equipment (PPE), we observed staff wearing masks and there were PPE disposal facilities in interview rooms.

Staff made sure equipment was well maintained, clean and in working order. Records showed the equipment had been calibrated.

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

Inadequate

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, the service manager, administration service manager, office manager and six administrators full time.

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

Since the increase in employed clinical staff, there had been more availability of clinics and prescribers.

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

Staff completed their mandatory training with their substantive employers. The service requested evidence of completion of training which was stored on their staff file. There was a training and development policy which listed the mandatory training requirements. Administrative staff accessed eLearning that was arranged by the service, however their training was not included in the training matrix.

The mandatory training programme included conflict resolution, equality, diversity and human rights, information governance, Mental Capacity Act (Including Introduction to the Care Act), Prevent, WRAP, safeguarding adults' levels 2 and 3 and safeguarding children levels 2 and 3. We reviewed the training matrix and found there were three staff listed who were not included in the staff list, the administrators training was not included in the record either. This meant there was not accurate oversight of staff training records.

For clinicians, review of the training matrix showed two courses with compliance below 70%; 59% for conflict resolution and 64% for Mental Capacity Act. 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. At the last inspection, we issued a warning notice as we found clinicians were not considering and recording risk within appointments. At this inspection, we reviewed five 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.

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

Inadequate

Management of patient risk

Staff monitored patients on waiting lists for changes in their level of risk and responded when risk increased. Since the last inspection, the service had introduced a one page resource document which was sent out to all new referrals. This document explained there would be a wait for the service and the impact of COVID19. The leaflet also provided information about where patients could go for support whilst they were waiting.

We reviewed the system in place for referrals and appointments. There were 645 referrals waiting for screening. Following screening the referrals were added to the referrals received spreadsheet. Since the last inspection, the service had progressed with developing a system to manage and respond to referrals and a review of the system showed the oldest referral for a first appointment was from 18 November 2021.

An automatic reply had been added to all emails received including referrals, the reply included the current waiting time of between three and four months and where patients could go for support whilst they were waiting.

During COVID19, the service was offering welfare calls to patients and continued to offer a smaller number of welfare calls at the time of inspection. Records confirmed welfare calls had been requested by the administration team if they were concerned about a patient, the calls had taken place and notes recorded.

Staff did not follow clear personal safety protocols, including for lone working. The lone worker policy dated 2019 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. However, training records did not show what training administrative staff had completed.

Staff kept up-to-date with their safeguarding training. Compliance levels for both safeguarding adults and safeguarding children level 3 was 82%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

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 submitted statutory notifications in relation to abuse or allegations of abuse and included the actions they had taken.

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 was historically only accessible to the administrators, registered manager, clinical leads and one non-medical prescriber. However, since the last inspection, all clinicians now had read only access to the system. However, this meant clinicians could not add to the system, including details of their appointments. 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 the letters for typing folder and found the oldest letter was dated 9 February 2022. This was 48 days before the inspection. Four patients we spoke with were concerned about the delay in receiving their reports following their appointment. A review of the senior management team meeting minutes from 2 November 2021 showed that two clinicians had left without completing their assessments and other staff had to pick up this work. This meant there was a delay and inconsistency for patients.

We reviewed 11 care records. We found four incomplete records with observations missing and a clinic letter that had not been sent to the GP or patient, another with incorrect medicine dosage on the clinic summary sent to the GP and missing clinic summaries.

Since the last inspection, clinicians now had access to the individual electronic files which included their referral, appointment summaries, copies of prescriptions and complaints information. However, these files were difficult to locate the required information, there were patients with the same name, there was a significant number of documents within the folders, especially for patients that had been with the service a while. There was no naming convention for documents and one sub folder for prescriptions. Administrators no longer needed to email clinicians prior to the appointments, and they talked about introducing more sub folders to organise the records and improve access to information.

The administration team had started to record activities and notes on the electronic patient records, including phone calls received and they had also started to record tasks on the system of booking appointments to reduce the use of spreadsheets. Training had been planned for clinicians to learn how to use the electronic record system.

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. Most consultations were carried out remotely and prescriptions were posted directly to patients for dispensing at their preferred pharmacy. We found staff were not always following the same process as some prescriptions were sent recorded delivery and others were sent with a stamp. The service did not have a system in place to check whether each prescription had arrived with the patient and relied on the patient ringing up if it had not arrived. We looked at some records on the tracker and found it was not always clear who had signed for the prescription and sometimes the system had no record of where the prescription was. The service had sent out replacement prescriptions without checking it was safe to do so.

Protocols for managing repeat prescriptions were not robust. Prescription checks were made at the clinic and a list of repeat prescriptions required was sent to the prescriber on rota. During COVID 19 the majority of the appointments had been over the phone or video calls, patients then had to submit their observations to the service, this could be by an appointment with the GP or by visiting a pharmacy. We found the service had no oversight of this process. This meant that patients could be exposed to avoidable harm as they could be prescribed medicines without the prescriber checking appropriate health checks were in place to ensure it was safe to do so. Staff told us that physical health observations were reviewed by one member of staff before the prescription was sent to the prescriber. However, there was no record to say that observations had been checked and that they were within normal range, but prescribing staff

continued to issue prescriptions regardless. Two care records we reviewed showed the patients had a high pulse rate with no action taken by the prescriber. Another record showed a patients' medicines dose had been increased without the prescriber receiving, reviewing and recording the observations. We found prescriptions did not always get to patients in a timely manner as the date the service recorded a repeat prescription was due was incorrect, which may have resulted in patients missing their medicine.

Prescriptions were copied to patients' records for future reference. Prescription stationery was stored securely, however the clinic did not have a record of what prescription pads they kept at the location. This meant they would not have been able to identify if prescriptions went missing.

The service had three different systems where care records were recorded, which included an email account. This meant that records were not accessible in one system, which made it difficult for staff to support the delivery of safe and effective care.

Information was still not being shared with patients' GPs in a timely way. Staff told us that there was two months' backlog of letters for GPs. The letters were sent to patients at the same time. This meant patients and their GPs were not informed of the outcome of the appointment timely, this could be a diagnosis where the outcome letter was crucial for support and reasonable adjustments.

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. Staff told us and records confirmed that incident report forms were not being used. The incident reported policy, reviewed 24 March 2022 stated, "It is our policy that all incidents are reported using the incident report form." This meant staff were not following the policy.

Medicines incidents were not clearly logged so that themes and trends could be identified, and prompt action could be taken to bring about improvement. Protocols did not describe how lost or incorrectly written prescriptions should be managed by staff. Managers had created an additional prescription database for when they have had to send out another prescription due to a prescription being lost or incorrectly written. The headings were patient name, date prescription was requested, reason for request, date issued, medication and dosage. There was no record of action taken, learning, themes etc. We reviewed minutes and found incidents were not discussed at the admin meetings. No multidisciplinary meetings had taken place in the last six months.

There had not been any audits of medicines or prescribing since the last inspection in October 2021.

Since the last inspection, an incident database had been introduced and included Ref. Number, Date Incident Received, Received by Initials, Description of Incident, Incident reviewed By, Outcome SI/Incident Declared, Outcome including Actions taken, Date resolved, Date fed back to patient, Name of Staff Member. The actions included duty of candour letter.

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

Inadequate

Managers did investigate incidents thoroughly. Patients and their families were involved in these investigations. 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 incidents on 5 April 2022, showed that investigations took place for serious incidents following the serious incident framework, with actions identified. Initial duty of candour letters were sent out to apologise following a phone call to apologise. Folders for local incidents, serious incidents and additional prescription requests had been created with a sub folder for each incident which included the investigation and correspondence. For one incident reviewed, a conclusion letter was sent to the patient, however it did not include the findings of the investigation and an offer of a copy of the full report. This meant the service was not sharing the findings of investigations with patients.

Staff at the senior managers meeting received feedback from investigation of incidents. However, clinical staff did not receive the feedback.

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

Good

Our rating of effective improved. We rated it as good.

Assessment of needs and planning of care

Staff undertook functional assessments when assessing the needs of patients who would benefit. They worked with patients and with families and carers to develop individual plans, and reviewed them as needed.

Staff completed a comprehensive mental health assessment of each patient. Patients may only have one appointment with LANCuk or may have several appointments dependent on need. Most referrals were initially assessed by a mental health nurse practitioner, who completed the social background assessment and if there were characteristics of one of the neurological conditions, a further assessment would be planned with either a nurse specialist or a consultant psychiatrist. This was usually with a different practitioner for impartiality and objectivity as part of the diagnosis process. If needs were identified in relation to speech and language, an appointment could be made with the speech and language therapist.

Assessments included the Autism Diagnostic Observation Schedule which is a recognised assessment for diagnosing autism. Staff also used the Barkley Adult ADHD Rating Scale--IV (BAARS-IV), a recognised assessment process for diagnosing attention deficit hyperactivity disorder. For children the SNAP-IV was used as part of the ADHD assessment.

Staff made sure that patients had a full physical health assessment and knew about any physical health problems. We reviewed six care records in relation to health and prescribing of medicines. Physical health screening took place usually for patients with attention deficit hyperactivity disorder who were going to be prescribed medicine. Health screening included an electrocardiogram and a cardiology assessment if identified as necessary by the prescriber, these were coordinated by the patient's GP. Within the titration appointments, staff measured patients' blood pressure, pulse and weight if they were face to face appointments.

At the end of each appointment with clinicians, staff completed a summary letter which included the content of the appointment and their findings, this was sent to patient's GP and the patient.

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

Inadequate

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. Staff understood and applied National Institute for Health and Care Excellence guidelines in relation to neurological conditions.

Staff used recognised rating scales to assess and record severity and outcomes. They did not however, participate in clinical audit, benchmarking or quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service.

Staff delivered care in line with best practice and national guidance. The assessment process included a full clinical and psychosocial assessment of the person, a full developmental and psychiatric history, and observer reports and assessment of the person's mental state. Observer reports included from family members and those close to the patient, this was in line with National Institute for Health and Care Excellence guidance.

Staff used the Autism Diagnostic Observation Schedule formal assessment tool which is in line with National Institute for Health and Care Excellence guidance.

Since the last inspection the service had started to use the Camouflaging Autistic Traits Questionnaire (CAT-Q) which reflected recent assessment tools.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes. Staff used the Barkley Adult ADHD Rating Scale--IV (BAARS-IV) to assess and record the severity of patient conditions and care and treatment outcomes. For children the SNAP-IV was used as part of the ADHD assessment.

Staff made sure patients had support for their physical health needs, which was usually provided from their GP.

Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice. Following diagnosis, patients had a feedback appointment with the service. As part of this the coaching service was discussed. If people accessed the coaching service, this was person centred and goal focused, this could include making changes to their lifestyles.

Staff used technology to support patients. Appointment could take place via phone or video call. Whilst some patients preferred face to face appointments, other were happy with the phone or video calls, especially if they lived a distance from the service.

Staff did not take part in clinical audits, benchmarking and quality improvement initiatives. There had been no audits since the last inspection.

Skilled staff to deliver care

The service included the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had a full range of specialists to meet the needs of the patients. The service employed one psychological wellbeing practitioner, one mental health nurse and the service manager full time.

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

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care. Staff worked substantively for the NHS where they worked in specialist teams and accessed relevant training for their role. Two mental health nurses included the service manager had completed the Autism Diagnostic Observation Schedule training to enable them to assess and diagnose autism. A speech and language therapist had completed a post graduate certificate in autism.

We asked for the training matrix for staff. However, no training details were provided for the administration staff, we do not know if they accessed any training in relation to autism. The Think Autism and National strategy for autistic children, young people and adults: 2021 to 2026 states that learning disability and autism training should be provided for all health and adult social care staff across England. Managers gave each new member of staff a full induction to the service before they started work. There was an induction pack in place which was being reviewed by managers. We reviewed five staff files, and all contained completed inductions.

Managers supported staff through regular, constructive appraisals of their work. Of the five staff records we reviewed, none were due for an appraisal, however they had all been booked in for May 2022.

Managers supported staff through regular, constructive clinical supervision of their work. There was a supervision policy in place which included the procedure of having different frequencies of supervision dependent on the level of work clinicians did within the service. The supervision matrix did not include two staff that were on the training matrix and did not include one staff member that was on the staff list. However, of the 20 staff on the supervision matrix, they had all received supervision. In the five staff records reviewed, all staff had received supervision in the last two months.

Managers did not make sure staff attended regular team meetings or gave information from those they could not attend. There had not been any multidisciplinary meetings since the last inspection. However, the service manager had planned to reintroduce these in April 2022.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. This included attending conferences and supporting staff to train to become non-medical prescribers. Training sessions took place for non-medical prescribers, topics included cardiovascular management in ADHD and ADHD management, diagnosis in Emotionally Unstable Personality Disorder.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care.

Staff had not held regular multidisciplinary meetings since the last inspection.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. This occurred via emails or face to face discussions between clinicians.

Staff had effective working relationships with external teams and organisations. Support and guidance had been provided by the clinical commissioning group and lead commissioners since the last inspection with regular meetings and site visits. Contact had been made with GPs and referrers regarding patients.

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

Inadequate

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves.

Staff received training through their substantive employers and the matrix showed compliance as 64%. Eight staff had to provide up to date training evidence of attending Mental Capacity Act training.

There was a clear policy on the Mental Capacity Act, dated November 20218, however, staff we spoke with were not aware of the location of this policy.

Staff knew where to get accurate advice on Mental Capacity Act. This included involving advocates.

There were no patients at the time of the inspection where staff were making decisions in patients' best interests.

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

Good

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

We spoke with 11 patients and four family members during this inspection.

Patients were very positive about the coaching service, the person centredness of the service which was goal focused. Following diagnosis of ADHD, patients said the information provided was very helpful regarding their condition and medicines.

Staff were discreet, respectful, and responsive when caring for patients. Patients told us they though the service was individualised to their needs, staff were friendly and supportive.

Staff gave patients help, emotional support and advice when they needed it. In appointments we observed, staff were very friendly, relaxed and encouraging to patients, using skills in recounting information and reassuring patients.

Staff used appropriate communication methods to support patients to understand and manage their own care treatment or condition. In two of the assessments we observed, we saw the clinician use toys as part of the assessment, this helped to engage the children and put them at ease. Patients told us staff were patient and respectful, ensuring that questions were phrased in a clear and accessible way and understood if patients misinterpreted the question or gave an answer that may not directly relate to the question.

Staff directed patients to other services and supported them to access those services if they needed help. In one of the assessments we observed, we saw the clinician identify potential risks and areas of support for the patient and how to currently keep themself safe.

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

Inadequate

Patients said staff treated them well and behaved kindly. However, patients told us of challenges with getting through to the service on the phone, messages not being passed on and calls not returned. Four patients told us they had experienced delays in receiving reports following appointments.

Patients also said that not having consistency of clinicians meant their appointments could be with different clinicians and patients felt like they were explaining their story again. Patients said it would be helpful to know the timeframes and what to expect in between appointments and the content of the appointments, for example follow up appointments, to help with managing expectations. Also, if a patient scored high on a screening tool which may indicate another condition, they would like to be informed so that they can access support if needed.

Staff understood and respected the individual needs of each patient. Patients also said clinicians understood their condition, were knowledgeable and communicated in an accessible way.

Staff followed policy to keep patient information confidential. However, we were made aware of one clinician who used their own device to contact patients on a messaging service. We raised this with the service and managers were going to look into this issue.

Involvement in care

Staff informed and involved families and carers fully in assessments and in the design of care and treatment interventions.

Staff informed and involved families and carers appropriately.

Involvement of patients

Staff involved patients and gave them access to their assessments and appointment summaries.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). During the feedback appointment, if a diagnosis had been made, this was explained to the patient, and a discussion about the offer of having support from a coach, to understand their diagnosis more and set goals and develop strategies to work towards these. Patients told us the clinicians communicated well, were clear and concise and used language that was accessible to them.

Patients told us that staff gave them information about the medicine they had prescribed.

Patients could give feedback on the service and their treatment. There was a link to a feedback survey at the bottom of each email and a link to the complaints policy. In the waiting room there was a comments box with comment forms for patients to complete. We reviewed nine feedback forms which included positive feedback of the service being welcoming, making patients more relaxed and understanding their condition more. The only negative feedback was regarding appointments being cancelled.

Feedback regarding the coaching service had been collated. Completed feedback questionnaires from the link in the emails showed 159 people had completed the feedback, over 40% of patients were very satisfied with their last appointment. Over 60% of patients thought their appointment time was convenient. Over 70% of patients thought the support from the administrative team was positive. Over 70% of patients said their appointment started on time. Over 65% of patients were positive about the care they received from the service. Over 65% of patients trusted the service to

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Inadequate

make medical decisions in their best interest. Over 75% of patients thought the service answered their questions well. Over 75% of patients thought the staff explained their treatment options well. Over 70% of patients thought staff explained the next steps of their care well. Over 55% of patients were satisfied with the amount of time the staff spent with them to address their needs. This meant overall, patients were positive about the service they received.

There was a "you said we did" notice board in the corridor where appointments took place. Feedback and actions included the increase in number of administrators to improve the response to emails, removed the answer machine and increase the number of employed clinicians to reduce the waiting time.

Staff made sure patients could access advocacy services. Staff knew how to access advocacy services if needed.

Involvement of families and carers

We spoke with four family members.

Staff supported, informed and involved families or carers. Carers and families were encouraged to be involved in the assessment process and the coaching sessions, if this was the patients wish. Feedback regarding the assessment and diagnosis was provided to the patient and family members if they attended the feedback appointment. Staff gave family updates over the phone if needed. Families said the service had been really helpful and staff explained what was going to happen in the appointment.

Family were asked to complete ratings scales as part of the assessment process for attention deficit hyperactivity disorder.

Staff helped families to give feedback on the service. At the bottom of every email sent there was a link to a survey for people to give feedback and to the complaints policy. There was information on display about how to give feedback: a poster in the waiting room and a comments box with comment forms for families and carers to complete.

The service follows the principles of Ask, Listen, Do in relation to feedback, concerns and complaints. Family members told us of when they had provided feedback to the service and action was taken to avoid a reoccurrence. Family members said it would be helpful to understand the process at the service, with approximate waiting times between appointments to help with managing their expectations.

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

Good

Our rating of responsive stayed the same. We rated it as good.

Access and waiting times

The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff followed up patients who missed appointments.

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

Inadequate

The service had clear criteria to describe which patients they would offer services to and offered patients a place on waiting lists. The statement of purpose for the service dated November 2020, explained the eligibility criteria and the aims and objectives of the service.

The service met target times for seeing patients from referral to assessment and assessment to treatment. The service had a target of having the first appointment with new referrals within 12 weeks from the date of referral. We reviewed the referral information and saw that this was being achieved.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services.

Staff tried to contact people who did not attend appointments and offer support. Letters were sent out, asking patients to contact the service. Where concerns were identified staff offered welfare calls over the phone and signposted patients to services offering urgent support.

Patients had some flexibility and choice in the appointment times available. Appointments were available during the day, in evenings and at weekends. We saw if there was a particular preference for appointments times from a patient, these were recorded on the electronic record system to aid staff when booking appointments.

Staff worked hard to avoid cancelling appointments and when they had to they gave patients clear explanations and offered new appointments as soon as possible.

Appointments ran on time and staff informed patients when they did not. Patients told us and we observed appointments running on time.

The service used systems to help them monitor waiting lists/support patients. The system had changed and improved since the last inspection. There was less reliance on spread sheets and increased use of the electronic record system to record tasks for future appointments. We saw there were 645 referrals in the referral folder and 92 patients waiting for coaching. Sub folders had been created to store the referrals following triage. The oldest referral was received in November 2021, these were for patients where they were waiting for additional information from their GP. Referrals that were ready for an appointment were from January 2022. This meant they were meeting their target for referral to appointment.

Staff supported patients when they were referred, transferred between services, or needed physical health care. Since the last inspection, the service had introduced a one page resource document which was sent out to all new referrals. This document explained there would be a wait for the service and the impact of COVID19. The leaflet also provided information about where to go for support whilst waiting including crisis support.

The facilities promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care.

The service had increased the number of interview rooms to five. The rooms were on the ground floor and included the necessary equipment for the sessions including physical health measuring equipment and resources regarding autism and attention deficit hyperactivity disorder.

However, the waiting area and interview rooms were not welcoming for children and young people, there were no toys for them to play with or activities to engage with.

The service had considered and responded to the needs of patients with autism in the environment. The rooms were minimally decorated to avoid over stimulation. Patients we spoke with appreciated the minimalist environment.

Meeting the needs of all people who use the service

The service met the needs of most patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

Staff had the skills, or access to people with the skills, to communicate in the way that suited the patient.

The service could support and make adjustments for people with disabilities, communication needs or other specific needs. There was a ramp into the building and LANCuk was based on the ground floor. The service had a hearing loop installed. During COVID19 virtual appointments had been offered over video calls or telephone calls. These were still available, and some patients preferred these.

Staff made sure patients could access information on treatment, local services and their rights. Information on how to complain was provided at the bottom of emails and this included a link to the complaints policy.

During the assessment appointments for children and young people, we observed the clinicians using pictures, stories and toys. However, the service did not provide information in a variety of accessible formats so the patients could understand more easily. There was no service user guide or information leaflet provided to patients.

The service did not have information leaflets available in languages spoken by the patients and local community. Information was only available in English.

Managers made sure staff and patients could get hold of interpreters or signers when needed. The service had a contract with an interpreting service where they could book interpreters for a variety of languages including British Sign Language. Records showed the process and confirmation for booking an interpreter. Appointment letters confirmed this with patients too.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

The service provided information on how to complain about the service in the footer of emails and this included a link to the complaints policy, however this was an old version. There was also a feedback box available in reception for people to provide feedback. However, patients, relatives and carers we spoke to did not know how to complain or raise concerns. The majority of people we spoke with had been having remote appointments and would not be able to access the comments box. Two out of the 11 patients we spoke to said they had been asked for feedback about the service. The service did not provide patients with any information about the service, for example a guide or welcome booklet which included how to give feedback. This meant people did not fully understand how to give feedback about the service.

Staff understood the policy on complaints and knew how to handle them. Since the last inspection, the complaints policy had been updated to include a flowchart of process and the service had introduced a complaints database which

included a reference number, type of complaint, when it was raised, the nature of the complaint, who had been allocated to investigate, outcome, when it was resolved and when it was feedback to the person making the complaint. There were individual folders for each complaint which included the documents associated with the complaint and the investigation.

Managers investigated complaints and identified themes. The outcome was included on the database.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We reviewed one formal complaint and found the letters and outcome were shared with the person who complained and were discussed in the senior managers meetings.

Managers shared feedback from complaints with staff and learning was used to improve the service. Improvements included offering face to face appointments.

Are Community mental health services for people with a learning disability or autism 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, knowledge 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 provide clinical leadership. The registered manager had been absent from work since January 2022, during this time the lead NHS Clinical Commissioning Group and associate Clinical Commissioning Groups devised a package of support and provided guidance to the service until the 25 March 2022. The service manager started in post on 14 February 2022 and were in the process of applying to be the registered manager. They were one of the non-medical prescribers and provided clinics as well as leadership.

Leaders had the skills, knowledge and experience to perform their roles. The service manager had been a manager prior to joining LANCuk. They were a non medical prescriber and qualified to complete Autism assessments.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to improve the quality of care. The service manager had identified areas for improvement and had started to implement these when we inspected, for example they had identified a number of patients who could be transferred to their GP for prescribing under shared care and the planned clinics were titration to review patients and decide if they were appropriate for shared care.

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

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

Inadequate

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 there had been no multidisciplinary team meetings. However, the senior management team met fortnightly, agenda items were complaints, recruitment and occasionally prescriptions. 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. One of the administrators had been given the responsibility to oversee the booking of new referrals and coordinating the appointments process. Three permanent clinicians had been recruited who provided 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. Staff had recently been sent a self-appraisal form to complete prior to their appraisal. We viewed a completed form which stated how supported and welcomed the staff member felt and appreciated the opportunity to develop their skills and enhance their knowledge.

Staff we spoke with felt supported and satisfied in their role and reported low levels of stress.

Staff feel valued and part of the organisation's future direction. Staff told us there had been positive change since the new service manager had joined the service and the support from the clinical commissioning group to introduce more systems including triaging of referrals and that there had been an improvement in communication.

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 welcomed to the organisation and supported to do additional training.

Staff had not had any appraisals since the last inspection however, they were planned in for May 2022 and self-appraisal forms had been sent to staff in preparation for this.

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. There was no health screening at recruitment. This meant staff did not have any reasonable adjustments that may be needed for health reasons.

The service did not monitor morale, job satisfaction and sense of empowerment, there were no staff surveys or feedback that took place.

The team worked well together however, there had not been any multidisciplinary team meetings since the last inspection. This meant staff were not given the 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.

There was no standard agenda for the administration or senior management meetings. This meant the service did not ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

There was no themes collated from incident reviews. Actions were taken following individual incidents reviews, however these were not shared with staff to avoid a reoccurrence.

Following the conclusion of any investigations involving patients, although the service wrote to the patients, they did not share the investigation findings with them.

During the tour of the service, we found FP10s (prescription documentation) were stored safely but there was no record of serial numbers. This is an essential part of the prescription security process, as it allows the identification of missing prescriptions. We found two FP10s that were not in consecutive numbers within two random samples taken. This meant the service did not have oversight of the prescription management process to mitigate the possible misuse of prescriptions.

Staff did not undertake or participate in local clinical audits. There had not been any prescribing, records and clinic outcome audits completed since the last inspection. This meant leaders did not know how the service was performing and where the areas for improvement were.

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

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

Care Act 2008 (Regulated Activities) Regulations 2014. We reviewed five staff files and none of the files had heath screening in. Two staff files did not have a full CV including gaps in their employment history.

Staff had to use their own mobile phones to contact patients, none were provided by the service. We found a staff member conducting their remote consultations via a messaging service, this meant that the patient would have had the number of the staff member. There was no policy or procedure in relation to this. However, when raised with the service they were going to discuss this with the clinician. The leaders and systems had not identified this as an issue.

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 were adapted from others, the LANCuk Information Governance and Management Policy 2018 referred to the practice. Staff were not following the policy. It stated, "All entries in patients' health records by any professional, should be dated, timed and signed with the signature, and designation of the signatory". Clinicians were not able to add information to the electronic care record, they could only read the information. They continued to email their summary to the administration team for adding to the system and sending to the patient and GP. This meant records were not complete and contemporaneous.

Staff maintained and had access to the risk register. This had been recently updated to show progress against actions. Staff concerns mainly matched those on the risk register. However, the prescription oversight had not been added to the risk register or the requirements from the last inspection.

Due to the service recently recruiting three permanent clinicians, systems were being developed to monitor sickness and absence rates.

The oversight of prescribing arrangements had not improved since the last inspection. During the review of medicine records and processes, we found that staff were not following the same process when posting out prescriptions to patients. Some were tracked and some were sent first class, there was no audit trail for this. This meant the service did not have oversight of the prescription management process to mitigate the possible misuse of prescriptions and location of undelivered prescriptions.

When prescriptions were not delivered to the address, or the patient said they did not sign for the prescription, the provider issued a new prescription and did not report the prescription as missing or escalate this with the postal delivery service. We saw from February 2022 to end of March 2022 that there had been six occasions of a prescription not being received by a patient. There was no further action taken by the service, including reporting to the local controlled drugs accountable officer. Best practice guidance requires providers to ensure that governance arrangements and processes are in place for the safe transport of prescriptions for controlled drugs if couriers, taxis or equivalent services are used.

We found the spreadsheet of when prescriptions were due to be issued recorded incorrect dates and were either too early or too late for patients' needs in three of the six records reviewed relating to prescribing. This was the system used to make sure people receive their medicines on repeat. We also saw increased doses of medicine not being prescribed. Therefore, there was not an effective process in place for communicating this change. This meant the patient was not able to access their intended treatment in a timely way. Where patients did not have access to a timely supply of their medicines, this may increase the risk of loss of control of the medical condition for which medicines were prescribed.

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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 had started to add these to the electronic care record and then had to copy this into the patient folder on the shared drive.

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. Clinicians were not able to add information to the electronic care records, however they could read the information and had access to the shared drive for patient records which avoided the administration staff having to email large amounts of personal information regarding patients prior to appointments. The answer machines had been switched off now which meant the phones rang for considerable lengths of time prior to being answered. Patients we spoke with told us how frustrating it was when trying to speak to someone at the service on the phone. Clinicians did not have work phones.

Information governance systems did not include confidentiality of patient records. There had been incidents of breached confidentiality where information had been sent to the wrong patient who had the same name as the intended recipient. LANCuk Information Governance and Management Policy 2018 stated that “There should be a unique identifier for each patient attending LANCuk, with a corresponding set of health records.” This was not happening, patients were referred to by their name, even though there were several contracts and several people with the same name. This meant that there could be a delay in accessing a patients record. Since December 2021, there had been six incidents including a near miss of breaches of confidentiality. Actions included using the electronic care letter to create the letter to the GP and patient, as the mail merge feature ensures the correct details are on the system and it adds the letter to the system automatically. The responsibility was on the administrator to proof-read the letter prior to sending, there was no checks from clinicians prior to sending.

The 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.

The service ensured service confidentiality agreements were clearly explained including in relation to the sharing of information and data. This was included in the induction checklist and information governance policy.

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

Inadequate

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 case manager for each patient, a transition service and a school liaison officer. These were not in place at the time of the inspection. The service did not create bulletins and newsletters.

Patients and carers did not have opportunities to give feedback on the service they received in a manner that reflected their individual needs. There were feedback forms in place and an electronic survey in the email footer, but no annual feedback form was sent out to all patients and there was no formal, proactive method of gaining feedback from families and carers.

Learning, continuous improvement and innovation

The organisation encourages creativity and innovation to ensure up to date evidence based practice is implemented and imbedded. Since the last inspection the service had started to use the Camouflaging Autistic Traits Questionnaire (CAT-Q) which reflected recent assessment tools.

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

Staff had not had an appraisal although they were booked for May 2022.

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

The service did not have any students on placement.

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.

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 17 HSCA (RA) Regulations 2014 Good governance • Records were not complete and contemporaneous. Four of the nine records reviewed had information missing. **17 (1) (2) (c)** • Staff records did not meet the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We reviewed five staff files and none of the files had heath screening in. Two staff files did not have a full CV including gaps in their employment history. **17 (1) (2) (d)**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not have oversight of the prescription management process to mitigate the possible misuse of prescriptions and ensure it was safe or appropriate to increase the dose of the medicine before prescribing or continue to prescribe for patients when clinically appropriate to do so. **12(1) (2) (g)**

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not have an effective system for the oversight of dispensing prescriptions to ensure medicines were provided to patients securely and within the time period specified within treatment plans. Staff did not engage in clinical audit to evaluate the quality of care they provided.**17 (1) (2) (a)**