Ridouts Professional Services Ltd
7-10 Chandos Street | London W1G 9DQ
T 0207 317 0340 F 020 7935 8310
E info@ridout-law.com W www.ridout-law.com

National Complaints Team
Care Quality Commission
National Customer Service Centre
Citygate, Gallowgate
Newcastle upon Tyne
NE1 4PA

By email only to: enquiries@cqc.org.uk; complaints@cqc.org.uk

11 March 2024

Dear Sir or Madam

Our Client: ADHD 360 Ltd
Inspection number: INS2-17062735451
Complaint

1. We act for the Registered Provider, ADHD 360 Ltd ("our Client").

2. We are instructed to submit to you a formal complaint in relation to inspection that took place on 25 August 2023.

3. This complaint is made on the following grounds:
   a. Administrative mistakes
   b. Unprofessional behaviour
   c. Not following policies and procedures

4. The following deals with each ground in turn:

Administrative mistakes

Number of staff

5. The draft inspection report (Annex 1) stated:

   *"The provider did not have safe processes and procedures to manage and monitor blank controlled drug prescriptions**. We saw that multiple staff had access to the key safe** and*

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therefore potentially to the prescriptions. We were not able to determine if any prescriptions were missing." [Emphasis added]

6. This statement was challenged in the factual accuracy form (Annex 2) at row B1. In response the CQC stated:

   "Thank you for your comments.
   The report has been amended to reflect your feedback. The report now reads:

   ***We were told on the day of the inspection that more than one person had access to the key safe to obtain keys to a variety of filing cabinets including those containing blank controlled prescriptions in the building**."* [Emphasis added]

7. The final inspection report (Annex 3), published on the CQC website stated:

   "The provider did not have safe processes and procedures to manage and monitor blank controlled drug prescriptions. ***We were told on the day of inspection that several staff***
   We were told on the day of inspection that more than one person had access *to the key safe….."* [Emphasis added].

8. The CQC chose, not only to ignore our challenge that words such as 'multiple', 'several' and 'more than one' should be removed from the report and replaced with the fact that four out of 151 staff members had access to the key safe; the CQC made an administrative error by repeating references to the number of staff, in this case reference to 'several' as well as 'more than one person'.

9. The report currently published on the CQC's website still contains the error, despite the CQC being informed in a letter dated 15 December 2023 (Annex 4). The report remains inaccurate and contains a clear error that needs to be acknowledged and corrected.

Inspection framework

10. The service was inspected on 17 November 2020 under the category 'Independent Mental Health Service' by a team that included a hospitals mental health inspector. The inspection report (see Annex 10) was signed by [redacted], Deputy Chief Inspector, Hospitals Director, mental health lead. The framework applied to the service at inspection was incorrect. The service is not a hospital, but was inspected as such which led to the CQC criticizing the service for not having ligature precautions in place, despite the fact that patients are never left alone on assessment rooms. Nevertheless, our Client made the improvements recommended by the CQC in that inspection.

11. It is apparent that the inspection on 25 August 2023 was not conducted under the same framework as the previous inspection on 17 November 2020. The Registered Manager raised this concern with the Lead Inspector at their registered manager interview who accepted that

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there had been a change to the category of service/framework for inspection and that our Client had not been informed of the change. The CQC has illustrated a lack of understanding of the type of service ADHD 360 is and as a result have failed to place the service in the appropriate category. Whilst the CQC has recently moved to a single assessment framework, that does not negate CQC's obligation in August 2023 to inform our Client of a change to the category of service/framework for inspection. Our Client seeks a full explanation in CQC's response to this complaint.

Report of Actions

12. It also is a matter of record that the CQC's Report of Actions is set to the wording and requirements of the original draft of the inspection report, and has not been amended for the final published inspection report. When challenged, the CQC were incredibly hostile and refused on many occasions to either waive the action plan deadline or even acknowledge the inconsistency between the versions, and that the required action was impossible to activate due to the inconsistencies and the factual errors in the required action. After significant effort by ADHD 360, the requirement for the action plan was 'suspended' and currently ADHD 360 have no guidance as to how to proceed.

Unprofessional behaviour

Rude and hostile

13. On the day of the inspection, the Lead Inspector, acted unprofessionally. She was incredibly rude and hostile. The service does not have a reception area so staff informed the Head of Operations, when they noticed strangers within the grounds of the building. Not knowing who the individuals were, the Head of Operation went outside and politely asked if they required any help, to which the Lead Inspector sharply responded *"No"*. Met with such an abrupt and abrasive response, the Head of Operations asked *"Can I ask who you are?",* to which the lead inspector responded *"I am waiting for another colleague to arrive and we will identify ourselves once we have crossed the threshold."* The Head of Operations returned inside the building and waited for the individuals to enter. It was not until the individuals were inside the building and let into a meeting room that they introduced themselves as inspectors and showed their ID.

14. It is obvious that such conduct is unprofessional, inappropriate and illustrates the way in which CQC inspectors use their powers to demean and oppress Providers. The Provider has a legal duty under Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to keep premises secure. This means that the Provider is within their rights to enquire as to the identity of visitors to ensure the security of their premises and safety of staff and service users. Section 62 of the Health and Social Care Act 2008 gives the CQC the power to enter and inspect a service. Section 62(5) places an obligation on the CQC to, *"if so*

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required produce some duly authenticated document showing the person's authority to exercise the power." There was absolutely no reason why the Lead Inspector could not have introduced themselves when on the grounds. Furthermore, to enable Provider's to uphold their regulatory obligations regarding premises security, Inspectors should not wait until they are in a meeting room before identifying themselves. This is appalling behaviour and should be addressed by the CQC.

15. The superiority exuded by the Lead Inspector when on the grounds of the service, permeates throughout the handling of our Client's factual accuracy submission. The Lead Inspector, led the previous inspection of the service on 17 November 2020 and displayed similar behaviour then. The Lead Inspector is determined to maintain negative assumptions about the service, despite being presented with evidence to the contrary. Our Client has been silenced and shut-down from the moment the CQC was on site.

Letters dated 14 and 15 December 2023

16. The CQC has acted unprofessionally, in the handling of our Client's factual accuracy submission and response to letters dated 14 December 2023 (Annex 5) and 15 December 2023 (Annex 4) (responses at Annexes 6 and 7).

17. The CQC makes unnecessary critical comments to stifle a Provider raising concern. The CQC criticising correspondence of 15 December 2023 (Annex 4) by stating, *"the tone of which we note is not constructive or helpful"* is unnecessarily combative. The letter of 15 December 2023 (Annex 4) merely sets out facts, some of which in response to assertions made by the CQC in previous correspondence, namely:

    a. It served of no purpose for the CQC to identify that the factual accuracy check was submitted *"on the agreed extension date"*. Therefore, our Client was within their rights to set out the fact that the extension was due to the draft report being unclear and further information being requested. The request was made on 7 November 2023 to [redacted], CQC Inspector (Annex 8). When [redacted]' automatic out of office was received, the request was forwarded to [redacted], Operations Manager, who immediately offered an extension which was accepted by our Client. [redacted] returned and responded to the request for information on 15 November 2023 (Annex 9).

    b. The following statement in the CQC's letter dated 18 December 2023 (Annex 7) is unprofessional, especially after commenting on the tone of our correspondence:

    "In your letter you refer to some CQC staff members being on leave and appear to question the propriety of our previous response. This is despite you sending correspondence out of hours in the very late evening of 14 December 2023, demanding a response before 12 noon the following date, 15 December 2023. One of CQC's employees attended a meeting to discuss the response notwithstanding that they were on leave."

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Our question was legitimate as the CQC Lawyer confirms that one of the CQC employees were on leave, also annual leave previously prevented the information request referred to above, being fulfilled on or around 7 November 2023, resulting in an extension of time to submit factual accuracy comments

18. Our letters dated 14 and 15 December 2023 (Annexes 4 and 5) have not been fully responded to. Our Client appreciates the CQC Lawyer seeking instructions out of hours from staff on leave to respond to the pressing issue of publication of the report. However, there has been no efforts to seek full instructions in a timely fashion. In the CQC's letter dated 18 December 2023 (Annex 7) the CQC stated:

    "However, as you note in your letter, given two of the members of staff with involvement in this matter are not currently available due to either leave or working patterns we will not be in a position to respond to your recent correspondence in full until we have been able to take further instructions…CQC does not consider that these justify the removal of the published report but will respond substantively in due course, once the relevant members of the team have returned from leave and we are able to take full instructions. "

    It remains unclear why the CQC produced and published an erroneous report, why publication was not suspended despite our letter dated 14 December 2023 and why the erroneous report remains on the CQC's website despite our letter dated 15 December 2023. It has been over two months and we have still not received a full response to our letters. There has been no update in the interim, and no explanation for the delay. The lack of a full response and lack of explanation regarding the delay is unprofessional.

Not following policies and procedure

19. The CQC's website states that the factual accuracy process *"gives inspectors and providers the opportunity to ensure that they **see and consider all relevant information** that will form the basis of CQC's judgements"* (emphasis added). The CQC has failed to follow this guidance as information submitted within the factual accuracy response has been willfully disregarded by the CQC and determined by the Inspector to *"sit outside the factual accuracy process"* which is clearly incorrect. Information provided by our Client, clearly relevant to the alleged concern(s) raised is required to be meaningfully considered by the CQC. Where deemed irrelevant, CQC are required, out of fairness to the Provider and as a competent regulator, to provide sufficient reasoning for their decision and not simply write *"Thank you for your comments, however they sit outside the factual accuracy process"* which is deficient and prevents the Provider from being able to fully engage with the factual accuracy process. The CQC make this statement 33 times throughout the factual accuracy response, illustrating a blatant disregard for the guidance, which goes to the very heart of the factual accuracy process.

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20. The CQC has entirely disregarded the following:

a. Accident and Incidents
   i. In the draft report the CQC asserted *"Not all staff had access to the incident recording and management system, this meant there was potentially a delay in putting measures in place to minimize the impact of the incident"*
   ii. In the factual accuracy submission our Client explained the reason why only Senior Managers and Directors administer the accident and incident management system, including that *"The quality of recording of the incident enables the service to make accurate decisions regarding the processing of the incident and actions to be taken."* Our Client explained that all staff have access to the incident recording system and therefore, there is no potential delay in the service putting measures in place.
   iii. In response to the factual accuracy submission the CQC stated simply, *"Thank you for your comments, we will amend the report to read as follows: "We were told not all staff had access to the incident reporting system."* And the final report still contained references to potential delay.
   iv. The CQC misinterpreted our Client's submissions as the statement "*not all staff had access to the incident reporting system"* is wrong. Not all staff have access to the incident **recording** system but have access to the incident **reporting** system.
   v. Furthermore, the CQC disregarded submissions regarding *"reporting" "recording", "putting measures in place"* and *"delay",* by responding *"Thank you for your comments, however they sit outside the factual accuracy process".*

b. Blank Prescriptions
   i. As per row B1 of Annex 2 and throughout the factual accuracy response, the CQC ignored submissions made immediately after the inspection, and then ignored submissions made as part of the factual accuracy process stating that they were not made immediately after the inspection. No matter when the evidence is presented it is ignored on the basis that it was not presented on a different occasion. The approach taken by the CQC suppresses the Provider into silence.
   ii. Submissions made post inspection were fulsome, explaining the service's serial number system which enabled the service to report to the CQC on 6 September 2023 that no prescription scripts were missing or unaccounted for. This was further explained in the factual accuracy submission with evidence. The CQC disregarded the explanation and evidence on the basis that points raised in the explanation/evidence were not referenced in the report, stating, *"Thank you for your comments, the report does not reference the serial numbers of blank controlled drug prescriptions and therefore does not form part of the factual accuracy process."* Then criticises the Provider for not providing the very evidence that the CQC rejects, stating, *"The provider*

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advised the CQC on 6 September 2023 that no scripts were missing or unaccounted for. However, no evidence was submitted as to how this decision had been reached."

c. Staff Dignity and Respect
   i. The CQC erroneously maintained that a reference to staff was a reference to patients. The CQC relied on an action log from July 2023 which correlates with minutes of a meeting in July 2023. The action log stated *"[NAME] to only report (more than one). When reporting complaints regarding the level of care to mention any repeat offenders."* The minutes stated. *"[NAME] to ask [NAME] – are there any repeat offenders of administrative errors in the clinical team…"*. Whilst it is clearer in the minutes that staff are being referred to, the CQC has, in the absence of evidence wrongly interpreted a linked document, the action log, as referring to patients. Complaints enable a service to identify administrative errors. This baseless misinterpretation has led the CQC to allegedly find the service in breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

d. Dose Discrepancies
   i. The CQC has greatly erred in relation to this allegation. Our Client explained its quality assurance process which includes the partner pharmacy sending the service a weekly report summarising prescription errors that were captured and rectified during their daily checks. This report is at the end of the quality assurance process and enables all prescription errors to be reviewed in one place. The report is reviewed by the service, the outcome of the review is circulated to clinicians with suggested improvements for the future.
   ii. At the inspection the CQC wrongly assumed that the report from the partner pharmacy identified unresolved errors. In the factual accuracy submission, it was explained that the report is produced on a regular basis as part of the service's quality assurance process and sits at the latter end of the quality assurance process. It was also explained that the quality assurance begins at the time of prescribing with the partner pharmacy cross referring details inputted by the Clinician on the electronic system Chrysalis, against the physical prescription. The Clinician is contacted the same day, and the error is rectified by the Clinician writing a new prescription. Evidence of this was submitted with the factual accuracy submission.
   iii. The next stage in the process was explained, it involves the service carrying out daily checks of photos of prescriptions received by Clinicians against the log of completed prescriptions also submitted by the Clinician on Chrysalis. The check takes place the morning after the prescriptions have been written. Any issues with prescriptions are flagged with Clinicians and the checks are made that afternoon to ensure the issues have been resolved. Evidence of this was provided with the factual accuracy submission.

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iv. The CQC ignored evidence of the various stages of quality assurance stage stating, *"We were not informed during the inspection or through data submission following the site visit of actions taken by the primary dispenser when errors on prescriptions are found."* During and immediately after the inspection, our Client was unaware that the CQC would make the assertions it did in the draft inspection report. The factual accuracy process is to identify inaccuracies. Our Client used the process to submit relevant information to evidence a system that was in place at the time of inspection. However, the CQC has not complied with its own policy and guidance as it has failed to consider all relevant information on the basis that it was not submitted previously. The inspection report still contains inaccuracies.

21. These examples highlighted above go to the very heart of the factual accuracy process and the CQC's failure to adhere to the guidance, and the spirit and principles of the factual accuracy process, have detrimentally impacted our Client's overall rating. By virtue of the CQC unduly fixating, conflating and failing to adequately consider the Provider's evidence, the Provider's ratings for Safe and Well-Led have been detrimentally impacted as well as the overall rating for the service mandating.

22. The CQC's failure to adhere to the guidance, and the spirit and principles of the factual accuracy process resulting in publication of an inaccurate report, is apparent when considering the Lincolnshire ICB's response to the CQC's alleged findings. By way of background, in the summer of 2023, ADHD 360 took part in a Rapid Quality Review ("RQR"), initiated by the Lincolnshire ICB (the CQC were invited to take part in this, and took part partially - attending one of the half a dozen meetings). At the end of the RQR, Lincolnshire ICB praised ADHD 360 and offered an extended contract for ADHD services. When the CQC report of its inspection was published, the ICB requested a meeting with ADHD 360 to discuss the findings and rating. When the two officers of the ICB attended that meeting and went through the report, they were visibly and outwardly shocked at the apparent contradictions between the report and the service, but also the contradictory evidence from different sections of the report itself. Moreover, the RQR process had taken place within the same period that the CQC had carried out the inspection and sought evidence. The result of each process differed widely, the RQR resulting in an extended contract and the inspection resulting in a Requires Improvement rating. This further contradiction was puzzling to Lincolnshire ICB. At the meeting, Lincolnshire ICB was assured that the matters raised within the report as areas for development, had been fully evidenced by ADHD 360 as meeting their standards; and the contract for ADHD services ordinarily continued.

23. Our Client has exhausted the CQC's rating review process with no success. It should not be necessary that Provider's seek judicial review before the CQC recognise legitimate concerns raised by Provider's regarding its failures and errors.

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Conclusion/outcome sought

24. Our Client has very grave concerns about the way in which the August 2023 inspection was conducted and reported on, and the risks these methods pose should the current inspection team continue to inspect the service. For this reason, our Client strongly requests a new inspection team for any subsequent inspections.

25. In addition, our Client seeks:

    a. Correction of the final inspection report published on the CQC website in accordance with row B1 of the factual accuracy response.
    b. A full explanation regarding the change service category/framework for inspection.
    c. A full response to the firm's letters dated 14 and 15 December 2023.
    d. A detailed re-evaluation of the service's rating, free from the bias shown previously, fully embracing the factual accuracy process, whereby the evidence is assessed in a balanced, proportionate and fair way.

Yours faithfully

RIDOUTS PROFESSIONAL SERVICES LTD.

Ridouts Professional Services Ltd
gemma@ridout-law.com