Chear Ltd

Chear, Shepreth

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	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Insufficient evidence to rate
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

We have not previously inspected this location. At this inspection, we rated it as requires improvement because:

- There were not effective systems and processes to maintain the overall governance of the service. We did not see evidence of sharing learning from incidents and complaints. There was no formalised approach to identify and manage risks within the service.
- The systems and processes to ensure policies and guidelines were reviewed was not effective. The service did not have audit processes to monitor the effectiveness of care and treatment and staff appraisals tended to be informal.
- Mandatory training for staff was limited and there was a lack of awareness of the risks to the service. Staff did not manage clinical waste well and equipment checks were not always documented.

However:

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse. Staff kept detailed, clear care records.
- Staff worked well together for the benefit of patients.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients.
- The service planned care to meet the needs of people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait for treatment.
- Staff felt respected, supported and valued.
- There was a strong focus on continuous learning and improvement.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Requires Improvement 	We have not previously rated this service. We rated it as requires improvement because we rated safe and well led as requires improvement and caring and responsive as good. We do not rate effective for diagnostic imaging services.

Summary of findings

Contents

Summary of this inspection

Background to Chear, Shepreth

Chear Shepreth is operated by Chear (Children's Hearing Evaluation and Amplification Resource) Limited, based in Royston in Hertfordshire. There is also a clinic in Bermondsey, London. They are an independent organisation for assessment of hearing in babies, children and adults. Patients aged over 19 are not in scope for registration with CQC for audiology services and therefore not part of our inspection. Chear registered with CQC in June 2013 for diagnostic imaging services provided to patients aged 19 and younger. The service has a registered manager and has not been previously inspected by CQC. The registered manager is the Director of Chear, an audiologist who covers all the appointments. There is a second tester who provides support with appointments with children under five years old and an officer manager who covers reception, books appointments and supports with other admin duties.

How we carried out this inspection

The inspection team was comprised of a CQC lead inspector and a CQC inspector. The inspection team was overseen by an Inspection Manager and Head of Hospital Inspection.

During our inspection, we spoke to the registered manager and the office manager. We also observed two appointments and spoke to the patients' parents. We reviewed three patient records.

Following the inspection, we spoke to another parent and a member of staff.

Outstanding practice

We found the following outstanding practice:

- There were innovative approaches to providing person-centred care, particularly for children with complex needs. The team adapted to the needs of each patient; this helped ensure they achieved a result for patients who had not been tested successfully elsewhere.
- The service had been involved in the development of new equipment. They worked with an engineering company to produce a new Warbler, which is a type of audiometer used for evaluating hearing acuity. The warbler allowed sounds to be presented without giving any visual cues.
- Functional hearing outcomes were measured as standard. This relates to understanding the quality of sound being heard.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust 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:

We told the service that it must take action to bring services into line with legal requirements. This action related to diagnostic imaging services.

Summary of this inspection

- The provider must review their local governance arrangements to ensure there are appropriate, up to date policies, risk assessments and staff training. HSCA RA Regulations 2014: Regulation 17 Good Governance (1)(2)(b)
- The provider must ensure there is an effective clinical audit programme and a documented system for staff appraisals. HSCA RA Regulations 2014: Regulation 17 Good Governance (1)(2)(a).

Action the service SHOULD take to improve:

We told the service that it should take action because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

- The service should ensure there is an effective process for disposal of clinical waste.
- The service should ensure equipment checks are completed and documented.
- The service should ensure all staff have an up to date Disclosure and Barring Service (DBS) check.
- The service should have access to translation services.
- The service should consider implementing a formal vision and strategy

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Requires Improvement	Insufficient evidence to rate	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Insufficient evidence to rate	Good	Good	Requires Improvement	Requires Improvement

Requires Improvement

Diagnostic imaging

Safe	Requires Improvement
Effective	Insufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Requires Improvement

Are Diagnostic imaging safe?

Requires Improvement

We have not previously inspected this service. At this inspection, we rated safe as requires improvement because:

Mandatory training

The service provided mandatory training in some areas and had a system to ensure everyone completed it. However, there was a limited number of courses staff were expected to complete.

The mandatory training was minimal, and we were not assured it met the needs of patients and staff.

All staff had recently completed training in Infection Prevention Control (IPC). Two staff had completed information governance and one had completed health and safety. The designated first aider did not have up to date training, however this had been booked for July 2021.

Managers monitored mandatory training and alerted staff when they needed to update their training.

The office manager monitored mandatory training completion via a diary system.

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 received training specific for their role on how to recognise and report abuse.

The safeguarding lead had completed level 3 training. The service worked closely with another organisation and if they needed advice or guidance relating to safeguarding there was a team there for them to contact.

Staff knew how to identify children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Diagnostic imaging

Staff gave examples of safeguarding concerns and described the process they would follow.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

There was a safeguarding policy which referred to up to date guidance and relevant legislation. It included contact details for the local safeguarding team. The safeguarding lead was not named as the escalation person within the service, but given the size of the service, everyone knew who to go to. If a concern was identified there was a form to complete and send to the local authority.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The clinic room, toilet, staff room, reception and waiting area were clean and had suitable furnishings which were clean and well-maintained.

Staff followed infection control principles including the use of personal protective equipment (PPE).

There was an infection control policy. All staff wore masks. There were suitable handwashing facilities and hand sanitiser gels available in both the reception/waiting room area and the clinic room. We observed the use of hand gel between patients.

Staff cleaned equipment and toys after patient contact.

There were no cleaning schedules, but the service had a cleaner who came every week. There was a log in the reception area and toilet which had been completed for the week of the inspection. We observed staff cleaning surfaces, equipment and toys between patients.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. However, staff did not manage clinical waste well.

The design of the environment followed national guidance.

The waiting area had chairs spaced and labelled for social distancing.

Staff carried out daily safety checks of specialist equipment.

We were told that daily, weekly and monthly checks were completed; these were not formally recorded so we saw no evidence of this. An external company completed the annual servicing and equipment could be sent to them in between if necessary. The hearing equipment was checked and calibrated in February 2021 and PAT testing has been done on other equipment in April 2020.

The service had suitable facilities to meet the needs of patients' families.

Requires Improvement

Diagnostic imaging

The clinic room was spacious, bright and airy. There was a small table and chair for the children. The desk was round, padded and covered to protect children who may wander around the room.

The service had enough suitable equipment to help them to safely care for patients.

There was equipment available for different types of test and as only one appointment took place at a time this was enough.

Emergency equipment was not required due to the nature of the service. A first aid kit was available and in-date.

Fire extinguishers were accessible, stored correctly and had been serviced within the last 12 months.

Staff did not dispose of clinical waste safely.

There was not an effective process for disposal of clinical waste. We were told that if a patient had an infection, the cleaner would take the waste to be disposed of at a GP practice, but this was very rare.

Assessing and responding to patient risk

Staff completed some risk assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Staff had limited awareness of the risks to the service, and it was unclear whether they had referred to the risk assessments.

There was a comprehensive risk assessment for COVID-19 and a general risk assessment had been completed for children with Social Communication Delay. They were not dated and did not have review dates on.

If a patient's behaviour became challenging, the parents tended to manage this. The toys that had been available in the waiting area had been removed due to COVID-19.

If a patient deteriorated physically in the waiting area, staff told us they would call for the first aider. Only one member of staff had completed first aid training, which had expired in November 2020. It had been extended to March 2021 and a three-day course booked for July 2021.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, there was no lone working policy.

The service had enough staff to keep patients safe.

The registered manager was the audiologist who completed all the appointments. There was one second tester who had recently qualified as a hearing aid dispenser and an office manager.

Requires Improvement

Diagnostic imaging

The service did not use bank or agency staff.

If the audiologist was unable to work, the office manager would cancel and rearrange the appointments. This was very rare.

There were no risk assessments or procedures to mitigate the risk of staff working alone. The premises were in an isolated location and on occasion the audiologist may have appointments while no other staff were on site.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily.

Records included full name and address, reason for the request, parent/carer opinion about hearing ability, speech development, ear, nose and throat (ENT) problem, family history, birth history and general development. If the parents had previous test results, the preference was for these not to be looked at until after the appointment as this was a second opinion service.

Records were stored securely.

All patient records were paper based and kept in a locked cupboard in the treatment room. Staff could access these as required.

Staff confirmed with patients that an email copy of the report as a PDF was acceptable and asked if they would like it encrypted.

Incidents

There was a process for staff to report patient safety incidents. The manager investigated incidents and shared lessons learned with the whole team. However, the sharing was mostly informal. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support.

The service had very few incidents. There was an accident logbook which staff were aware of to complete which included a description of what had happened, and any actions taken. If it related to a patient, details would be recorded in the patient record too. There was no incident policy or formalised process for the investigation and sharing of incidents. However, staff were able to give examples of incidents that had occurred over the past year. If they were not on site when something happened, they would be told by other staff when they returned.

Given how few incidents had occurred, there was limited evidence of changes made as a result. In one example, following wax removal, the patient had an ear infection. They considered whether this had been caused by them and disposed of one irrigator and the other one was deep cleaned.

Requires Improvement

Diagnostic imaging

Are Diagnostic imaging effective?

Insufficient evidence to rate

We do not rate effective for diagnostic services.

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice.

Staff did not always follow up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

We were told that monthly updates were received via email from the British Academy of Audiologists (BAA) and that the team reviewed any changes in guidance together. However, this was not documented anywhere or referenced in any policies. Most of the policies we reviewed did not reference any national guidance and the confidentiality policy referenced the Data Protection Act 1998 which had been superseded by the Data Protection Act 2018. There was also no reference to the General Data protection Requirement (GDPR).

Paper copies of policies were stored in a policy folder and staff knew how to access them. The policies we reviewed were all dated 2021 and we were told they would be reviewed annually. None of them included renewal dates, we raised this during the inspection, and these were added following our inspection.

Patient outcomes

The service did not have processes to monitor the effectiveness of care and treatment or use the findings to make improvements.

There are no national clinical audits for audiology.

There is no national clinical audit for hearing outcomes in NHS audiology services for the service to benchmark against. There was not a local comprehensive programme of repeated audits to check improvement over time. However, a recent audit had been completed.

The service did not collect data to monitor the service activity or effectiveness.

At the time of our inspection we observed appointments where the outcomes for the patients had exceeded the parents' expectations. However, the lack of audit meant there was no way of recording or evidencing it.

Managers used information from the audits to improve care and treatment.

Although only one audit had been completed, it had identified an area for improvement. A test to assess the quality of the child's hearing had shown that they were not getting validation as often as they thought – it was around 70% when expected to be 100%. There were no identified actions to improve on this and no planned re-audit.

Requires Improvement

Diagnostic imaging

Competent staff

The service made sure staff were competent for their roles. The manager appraised staff's work performance. However, the staff files did not contain evidence of regular 1-1s or appraisals.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work.

There was an induction checklist which included child protection, whistle blowing, record management, complaints, appraisals and training.

Managers supported staff to develop through constructive appraisals of their work.

While the staff files did not contain evidence of staff 1-1 meetings or annual appraisals, there were informal processes to assess staff competence and suitability. The files we reviewed included appraisals from 2018 and 2021. However, the manager worked closely with both members of the team, so appraisals were more informal on a day to day basis.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Team meetings were held monthly. These were minuted and we reviewed the last three months. Agenda items included patient survey results, training updates and workload plus some current items such as finding contacts for different types of referral.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Online lectures had been attended for training updates in remote care practice.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Opportunities to attend courses had been discussed with the office manager.

Managers made sure staff received any specialist training for their role.

Staff were supported to maintain and further develop their professional skills and experience. One member of staff had been supported to attend university and recently qualified as a hearing aid dispenser with plans to continue to become an audiologist.

Managers identified poor staff performance promptly and supported staff to improve.

Staff described being given feedback immediately after appointments. This included what had gone well and addressing any concerns. Staff found this more useful than waiting for formalised 1-1 sessions.

Multidisciplinary working

Requires Improvement

Diagnostic imaging

The staff worked together as a team to benefit patients. They supported each other to provide good care.

The registered manager (audiologist), second tester and office manager worked together for the benefit of patients and their families. We observed that their positive working relationships promoted a relaxed environment and helped put children and their families at ease.

Formal, monthly team meetings had recently been implemented.

MDT meetings were not attended, but the registered manager fed into them via sharing of reports. Interaction with NHS providers was also made using the BAA shared care protocol. This involved advising of any adjustments made to the child's hearing aids, if they had been provided by the NHS. Test results were shared with external organisations as required, for example local ENT teams, GPs, health visitors and teachers.

The registered manager attended weekly meetings with a charity they worked closely with, which provided rehabilitation services. Clinical input was given as required where they shared patients.

Seven-day services

Key services were not available seven days a week. However, staff worked in a flexible way to support timely care for children, young people and their families.

All appointments were arranged in advance. The service was open from 9am Monday to Friday with the last appointment booked for 4pm. There was flexibility at the end of the day to accommodate patients if required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The manager supported patients to make informed decisions about their care and treatment, followed national guidance to gain patients' consent and knew how to support patients who lacked capacity to make their own decisions. However, there was no consent policy and the other staff had not received training in consent.

The manager gained consent from patients for their care and treatment in line with legislation and guidance.

Most of the procedures were consented to verbally. There was a consent form to be signed for ear wax removal.

The manager understood how and when to assess whether a patient had the capacity to make decisions about their care.

The manager (audiologist) was present at all appointments and we observed verbal consent being obtained throughout. Children were spoken to directly and their understanding confirmed.

There were no policies to support staff to assess whether a patient had capacity to make decisions and consent to treatment. There was not a consent policy, staff had not received training in the Mental Capacity Act 2005 or the Children Acts 1989 and 2004 and were unaware of the Gillick competencies. However, neither of the staff would be responsible for gaining consent.

Requires Improvement

Diagnostic imaging

Are Diagnostic imaging caring?

Good

We have not previously inspected this service. At this inspection, we rated caring as good because:

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

People were always treated with dignity by those involved in their care. Staff were aware of any specific needs and found innovative ways to meet these. Families felt that their children were really cared for and that they mattered too. They felt that the team 'went the extra mile' when providing care and support.

Staff took time to build a relationship with the children to put them at ease before attempting the assessments. The manager would go out of her way to do what was necessary to achieve a successful outcome with the appointment. One parent of an autistic child, who had used the service for several years, told us that when her son did not want to come in to the clinic, the manager went to their car to speak to him and connect before encouraging him to attend the appointment. We were told that the manager understood his needs, listened and spoke to him and showed him respect. This was essential, otherwise he would not have co-operated.

Patients said staff treated them well and with kindness.

All the feedback we saw or heard about the service was positive in the way staff treated patients and their families. On the day of the inspection, in both appointments we observed, families told us that the care and treatment had exceeded their expectations. One parent told as that although his son was "usually very shy, they made him feel comfortable and their way with him was very good".

Staff followed policy to keep patient care and treatment confidential.

For all appointments where the child was under five years old, the second tester would be present to keep the child focused allowing the audiologist to complete the test. For those over five, the second tester would not necessarily be present; there was no chaperone policy, but the parents would always be in the room.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

The person-centred culture of the service was evident as each appointment was tailored for the individual child to ensure a successful outcome. Staff recognised and respected people's needs and found innovative ways to meet them.

Requires Improvement

Diagnostic imaging

One child, who was severely autistic, was unable to tolerate a hearing test. Following discussion of options with the family, arrangements were made for the child to be tested while he was asleep. The manager sent the family a video of what they needed to do with the equipment when they put their son to bed. The manager then visited them and carried out the test while the child slept. The alternative was for the child to have the test done under general anaesthetic, for which the waiting list was one year. Instead, the family came back to the clinic the following day and were provided with hearing aids.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

In frequent cases, the parents would be distressed by the result of the test. Staff took time to offer support and gave the option for a break in testing if needed. The appointments were long to ensure there was time for this. There was also the option to call the manager outside of appointments to ask further questions.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Emotional and social needs were as important as the physical needs. Staff recognised that people needed access to support networks. The report included details of organisations for the families to be referred on to, such as speech therapists. They also provided a listening guide which included ideas for developing listening skills. There was a poster in the waiting area with details of a lip-reading support group.

Constraints to practice due to COVID-19 were explained. For example, only one parent could attend the appointment and patients were made aware that clinicians would be wearing masks.

The website included an 'appointments and fees' section with details of the cost for different types of appointment and cancellation fees.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure patients and those close to them understood their care and treatment.

Patients and their families were active partners in their care. At the beginning of the appointment, parents were asked what they wanted from the test and a detailed history was taken. Throughout the appointment, questions were directed to the child and findings confirmed with the parent. For example, during a test, parents were involved and consulted throughout with explanations of findings being given.

Requires Improvement

Diagnostic imaging

Whilst involving the parents, the appointments were pitched towards the child. This ensured they gained a full picture of what the child's hearing experience was. For example, one child's parents were unaware they had tinnitus, because they had not told them. The manager discovered this by discussing not just the ability to hear, but the quality of the sounds the child was hearing.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

There was plenty of time at the end of the appointment to discuss the findings, where the reports would be sent and other services to be referred on to and ask questions. Families told us everything had been explained very clearly.

There was determination and creativity to overcome obstacles to delivering care. Patient's individual preferences and needs were always reflected in how care was delivered. For example, we observed staff doing a jigsaw puzzle with a young child at the start of their appointment, which enabled them to assess whether the child had the dexterity to complete the test they planned to use.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Following the appointment, test results were sent to the parents via email. Staff asked permission to include a link to their survey to provide feedback on the service. They had found this was more effective than trying to gain feedback immediately after the appointment, when the patient and family had not had time to think about it.

Patients gave positive feedback about the service.

We reviewed survey results for February, March and April 2021 which included several positive comments such as "For me no improvement is needed. Everyone is very polite welcoming and efficient. Work very well with children!". However, completion rates were low at between 31% and 34%.

There were over 35 thank you cards in reception with comments including: "Many thanks for successful appointment trying to get hearing threshold for our son, you did it"; "Thank you for helping our children finally hear clearly" and "Thank you for all that you have done to support our daughter this year – it is hugely appreciated".

Staff could give examples of how they used patient feedback to improve daily practice.

Air conditioning had been installed as a direct result of a patient who had struggled in the heat. The appointments could be very long, and this had helped patients feel more comfortable.

Are Diagnostic imaging responsive?

Good

We have not previously inspected this service. At this inspection, we rated responsive as good because:

Service delivery to meet the needs of local people

Requires Improvement

Diagnostic imaging

The service planned and provided care in a way that met the needs of children nationally. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population.

People's individual needs and preferences were central to the delivery of tailored services. There were innovative approaches to providing person-centred care, particularly for children with complex needs.

It had been identified that there was in increase in patients with Social Communication Delay and Autism Spectrum Disorder (ASD) accessing the service and new equipment had been purchased to accommodate these babies and children. New video screens were being used for children now engaged with screen images.

A further increase in demand for the service came as a result of COVID-19, because families had been unable to access audiology services via the NHS. This was still the case at the time of our inspection. The service had increased its opening hours to manage this.

Families were travelling from across the country for this service. At the time of our inspection a family had arrived from Newcastle and told us it was the only service offering appointments to children under two.

Facilities and premises were appropriate for the services being delivered.

The waiting area was comfortable with enough seating which allowed for social distancing. If patients arrived early for their appointments, they were asked to wait in their car. This was unlikely as there was enough spacing between appointments but prevented the risk of overcrowding at reception.

The needs of a range of people using the service were met. For example, adults were also treated at the clinic and when they arrived a table cover with a child-based design was removed.

Magazines and toys had been removed from the waiting area due to COVID-19.

There was free car parking directly outside the clinic, and the train station was a short distance away.

Information was given to patients regarding what to expect from the appointment at the time of booking and included in a confirmation email. There was a 'social story' document, which included pictures of the staff, equipment and surroundings which could be sent to the parents to help them explain to their child what to expect ahead of the appointment.

Managers monitored and took action to minimise missed appointments and ensured that patients who did not attend appointments were contacted.

The office manager sent appointment reminders to all patients the day before they were due to attend and would call any patient who did not arrive for their appointment.

Meeting people's individual needs

Requires Improvement

Diagnostic imaging

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The service had a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met these needs, which was accessible and promoted equality.

The tests were tailored to meet the needs of the child. The team adapted to the needs of each patient to ensure they got a successful result. Appointment times were lengthy to allow for this. For example, before attempting to take ear moulds from a child with autism, the audiologist gave him the mould so he could feel it with his hands first.

The service offered information about Assistive Listening Devices that could improve their lifestyle and safety, for example flashing fire alarms and doorbells.

The audiologist designed tests, for example an IPAD could be used where the child could touch the picture of what they heard. This enabled them to determine whether a child could distinguish between, for example, words such as 'key' and 'feet'.

There were transparent masks for use if a patient needed to lip read.

Signing interpreters could be arranged if required; if translation into other languages was needed this tended to be provided by families. This happened rarely.

There was a step into the clinic and at the time of our inspection they did not have a ramp. However, they had booked an appointment for a wheelchair user and arranged for a ramp to be made ahead of that.

Access and flow

People could access the service when they needed it and received the right care promptly.

People could access the right care at the right time. Patients were able to make an appointment within two weeks. Access to care was managed to take account of people's needs, including those with urgent needs. There was flexibility within the booking system to allow for urgent appointments.

The website included a section on 'tips for booking the correct appointment'. This helped patients request an appointment with an appropriate length of time allocated.

We saw no evidence of lengthy waiting times or delays to appointments and were told that cancellations were rare.

Remote appointments were available for online hearing aid adjustments.

There was an option to send broken hearing aids via special delivery if the patient could not attend the clinic. The audiologist would fix it (if possible) and return to the patient. One parent told us of an occasion when her child's hearing aid had broken and although she emailed the service in the evening, she received a prompt reply and the replacement was sent the same day.

Requires Improvement

Diagnostic imaging

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns.

Patients could complain by phone, email, letter or via a link on the website. There was an option to give feedback via the patient survey which was emailed with the test report.

The service clearly displayed information about how to raise a concern in patient areas.

There was a poster on the noticeboard in reception which detailed how to make a complaint, although this was small and not very clear. Complaint information had recently been added to the website, following feedback from a patient who had been unable to find information on the complaints process.

Staff understood the policy on complaints and knew how to handle them.

There was a complaints procedure for staff to follow. There were no time frames included in the procedure for initial response, but we were told the manager contacted complainants immediately. The procedure stated that they would aim to resolve complaints as soon as possible and allowed a time frame of six months.

Managers investigated complaints and identified themes. Learning was used to improve the service.

Two complaints had been received, both related to the children being distressed while their parent held them during a test. One parent had complained that their child had been distressed while they held them for the test. On another occasion a parent complained that a test had not been completed due to the distress caused to the child. Actions taken following these were that staff always confirmed with the parent whether they would like to proceed with the test.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Staff told us that complaints tended to come through via email. They were passed straight to the registered manager who would telephone the patient straight away. If she was unavailable staff would listen to their concerns and explain that the registered manager would be in touch.

Are Diagnostic imaging well-led?

Requires Improvement

We have not previously inspected this service. At this inspection, we rated well led as requires improvement because:

Leadership

Requires Improvement

Diagnostic imaging

The registered manager did not have all the skills and abilities to run the service. They understood and managed some of the priorities and issues the service faced. However, the manager was visible and approachable in the service for patients and staff and supported staff to develop their skills.

The Director of Chear was the Registered Manager and audiologist who carried out all the patient appointments. We were not assured of her skills to provide leadership of the governance within the service. There were not comprehensive systems to evidence that appropriate governance processes were in place. For example, there was not an effective system to identify, review and act on risks to the service. We were also not assured that the manager understood what policies and procedures were needed for the safe and effective delivery of the service. The service did not have policies for incidents, consent or lone working.

The manager had only completed mandatory training in safeguarding level two and IPC. The designated first aider's training had expired in November 2020 and was not due to complete training until July 2021. Although part of this delay had been caused by COVID-19, there was limited evidence of a comprehensive mandatory training programme for staff and oversight of completion.

Staff told us they felt well supported, describing the manager as approachable and feeling able to raise any concerns they had. Staff had been supported to develop and progress. For example, one member of staff was at university working towards becoming an audiologist with support working closely with the Registered Manager every day.

Vision and Strategy

The service did not have a vision for what it wanted to achieve or a strategy to turn it into action.

The service did not have a documented strategy or formalised vision. However, the manager was invested in improving services and using new technology.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Both members of staff spoke positively about the culture of the service. They felt supported by the manager and she felt supported by her team. Staff felt respected and valued and there was a sense of pride in the service provided.

There were processes to support staff and promote their positive wellbeing. Workload was a regular item on team meeting minutes and staff would support each other as required.

Staff felt able to raise concerns. There was a whistle blowing policy and staff were aware of a contact at a charity they worked closely with who they could approach if they had concerns they did not feel comfortable discussing with the manager.

There were opportunities to discuss training and development opportunities, although this was largely informal.

Requires Improvement

Diagnostic imaging

Prior to our inspection, we had fed back to the manager that there were areas of the service that required improvement. The registered manager responded positively to this feedback and some actions had been put in place, demonstrating an open culture of improvement.

Not all staff understood what the duty of candour (DoC) was, and it was not cited in the service policies and procedures. It was therefore unclear what the expectation of staff applying DoC was, but there had not been any incidents which would meet their criteria for formal duty of candour and was unlikely to be owing to the nature of the service.

Governance

Leaders did not operate effective governance processes. However, both staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Due to the size of the service, there were limited formal governance processes and we found there was a reliance on informal communication. We did not see evidence of sharing learning from incidents, complaints or audits. However, minuted monthly team meetings had recently been implemented.

The process for reviewing, updating and sharing of policies was not robust and we found examples where out of date guidance was referenced.

Mandatory training had been completed recently, but it was not clear what had been considered in determining what courses staff should undertake.

At the time of our inspection, there was not an audit programme to provide assurance of the quality and safety of the service.

None of the staff files contained evidence of employment references, and one member of staff did not have a (DBS) check. There was limited evidence available of staff appraisals, with the files only including documentation from 2018 and 2021. This meant we could not be assured that there was full oversight of the skills, suitability and capabilities of the staff. However, with a team of two, the manager worked closely alongside both members of staff every day.

Management of risk, issues and performance

There was limited evidence that the registered manager identified and escalated relevant risks and issues and identified actions to reduce their impact. There was no evidence that risks, and actions were discussed with the team. However, they had plans to cope with unexpected events.

There was no formalised approach to identify and manage risks within the service.

At the time of our inspection, two risk assessments had been completed. One was for COVID-19 and another was for children with Social Communication Delay. These were comprehensive, including mitigating actions and named staff assigned, but there were no review dates. Other risks to the service had been identified as cyber-attack, staff sickness and financial. There were no risk assessments for these, and no risk register. We identified occasions of lone working which had not been identified as a risk. There were no risk assessments for having one first aider, meaning there were occasions where there was no first aider on site; or for the member of staff who did not have a DBS, therefore we were not assured that the manager was aware of all the risks within the service.

Requires Improvement

Diagnostic imaging

A test had been completed for a patient with severe autism off-site. Discussions were held with the family, options considered, and a decision made for how to proceed, with consent. However, none of this was documented. There was no protocol or risk assessment recorded for this. Therefore, we were not assured that the manager was aware of her responsibilities around assessing risk.

Staff had limited awareness of the risks to the service and their mitigating actions.

However, the service had experienced a cyber-attack in the past and actions had been taken.

Information Management

The service did not collect reliable data and analyse it. The information systems were integrated and secure.

Both staff had recently completed information governance training. Patient records were easily accessible and kept secure. They were paper-based and stored in a locked cupboard in the treatment room. Staff records were kept in a locked cupboard behind reception.

The service had experienced a cyber-attack and learned from it. Their data was now backed up to the cloud. Patient reports were encrypted before circulation to other organisations.

However, there was limited evidence to suggest the service was collecting information to improve the performance of the service and the confidentiality policy referenced out of date guidance.

Engagement

Leaders and staff actively and openly engaged with patients and staff. Theycollaborated with partner organisations to help improve services for patients.

Patient feedback was gathered via a link included in the emails that were sent with the test report. This had been identified as more effective than asking patients for feedback immediately after the appointment.

There was a website for members of the public to use. The service was in the process of updating it, but it included information regarding the services offered and prices.

Staff felt involved in any changes and developments made within the service and told us they felt that their opinions mattered. They felt very involved in the improvements and changes being decided for the website.

The service had ongoing discussions with a Community NHS Trust and worked closely with an audiology charity.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

There was a strong focus on continuous learning and improvement. The registered manager was involved with numerous organisations and demonstrated a passionate drive for improving paediatric audiology services.

Requires Improvement

Diagnostic imaging

The registered manager worked with the British Academy of Audiology (BAA) in reviewing protocol for visual audiology; had close collaboration with British Society of Audiology (BSA), completing joint presentations at conferences and was also involved in Knowledge and Implementation in Paediatric Audiology (KIPA) regarding moving forward in paediatric audiology.

New equipment had been developed at Chear. They worked with an engineering company to produce a new Warbler, which is a type of audiometer used for evaluating hearing acuity. The warbler allowed sounds to be presented without giving any visual cues.

Functional hearing outcomes for hearing speech were measured as standard; we were told this was not typically made in equivalent NHS services. It involves assessing the child's hearing, then if they were a hearing aid wearer, measuring what the aid is doing. For example, by putting toys on the table to assess if the child could understand the difference between words such as horse and fork.

Creative solutions had been used for children including sending parents list of words to say whilst standing behind the child before the hearing aid adjustment was made.

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	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider must review their local governance arrangements to ensure there are appropriate, up to date policies, risk assessments and staff training. HSCA RA Regulations 2014: Regulation 17 Good Governance (1)(2)(b) • The provider must ensure there is an effective clinical audit programme and a documented system for staff appraisals. HSCA RA Regulations 2014: Regulation 17 Good Governance (1)(2)(a).