

Highfield ENT Clinic

Quality Report

Highfield Hospital
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Widnes
Cheshire
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Website:

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

Ratings

Overall rating for this location

Good



Are services safe?

Good



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Good



Overall summary

Highfield ENT Clinic is operated by Widnes Highfield Health Ltd. The service holds a contract with Warrington and Halton NHS Trust to provide an ear, nose and throat service. The service employs two ear care nurses that provide nurse led clinics during the week, and one health care assistant. There are two consultant led clinics provided two days per week, and the consultants are employed by Warrington and Halton NHS Trust. The

service takes referrals from GPs and aims to see patients within two weeks of referral. The service accepts both adults and children, however the numbers of children seen are low.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced visit on 4 March 2019. The consultants were not providing clinics on the day of inspection, and

Summary of findings

there was one ear care nurse on duty. We spoke to the ear care nurse, health care assistant, administrative staff and the registered manager. We spoke to three patients who attended the clinic.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

The service has not previously been inspected or rated.

We found the following areas of good practice:

- The service provided a wide range of mandatory training and had systems in place to ensure this was completed.
- Staff understood their safeguarding responsibilities and information was shared during team meetings and on the staff bulletin.
- The service used an electronic system for patient records which meant staff, patients and GPs had access to important information when they needed it.
- There were enough staff who were competent in their roles and had good support and mentoring from managers.
- Staff treated patients with compassion and patients' dignity and privacy was respected.
- The service established good links with the local area to help plan the service to meet the needs of local people.
- The service had clear admission and exclusion criteria.
- The service could offer patients an appointment within one to two weeks of referral and patients did not have to wait long in the waiting area.

We found the following issues that the service provider needs to improve:

- There was not always a suitable clean space for cleaning used equipment. This could pose a risk to the spread of infection. The service amended this immediately.
- Paper records were not always completed in line with best practice guidance. This was because entries were not always signed by the person making the entry which was not in line with the Royal College of Physicians record keeping standards 2015.
- The consent policy was not in line with general medical council guidance, putting both patients and staff at risk of not having proper discussions about treatment or documenting consent. It is important for patients to be fully informed of the associated benefits and risks, before agreeing to treatment. However, when we discussed this with managers the service amended the policy immediately.
- Although the provider had a duty of candour policy this did not fully meet national guidance or legislation as it did not outline the relevant person should be notified of a moderate harm safety incident in writing.
- The service did not monitor outcomes of care and treatment. This meant the service missed opportunities to identify where the service could improve.
- The service did not have a system to highlight individual needs such as whether a patient had a sensory impairment or disability. The service was reliant on the GP referral form for information. This meant the service may not effectively plan for and meet the individual needs of patients.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with three requirement notice(s). Details are at the end of the report.

Ann Ford

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

**Community
health
services for
adults**

Rating

Good



Summary of each main service

Highfield ENT Clinic is part of a GP federation. The service holds a contract with Warrington and Halton Trust to deliver ear, nose and throat care to the local community.

We rated this service as good because we found that the service was good in safe, caring, responsive and well led.

The 'effective' key question required improvement and there was a breach in meeting the regulation around consent. Start here..

Summary of findings

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Good 

Highfield ENT Clinic

Services we looked at

Community health services for adults.

Summary of this inspection

Background to Highfield ENT Clinic

Highfield ENT Clinic was operated by Widnes Highfield Health Ltd. The service focussed on the communities of Halton and accepted referrals from GPs for both adults and children. However, the numbers of children seen were low. The service offered 12 nurse led clinics per week and two consultant led clinics per week. Consultants were employed by the local trust.

For the nurse led ear care service from July 2018 to December 2018, the service received 282 new referrals, 13 of which were for children. There were 1350 follow up appointments, 66 of which were for children.

For the consultant led ear, nose and throat service from July 2018 to December 2018, the service received 342 new referrals, 14 of which were for children. There were 94 follow up appointments, 3 of which were for children.

Highfield was part of a GP federation alongside other practices in the area. Highfield provided ear, nose and throat care to the local area and was set up to ease pressure on local hospitals and to increase access of services to local patients.

The regulated activities are diagnostic and screening procedures, surgical procedures and treatment of disease, disorder or injury, with a registered manager in place.

We inspected the service on 4 March 2019 and was the first time the service has been inspected.

The consultants were not providing clinics on the day of inspection, and there was one ear care nurse on duty. We spoke to the ear care nurse, health care assistant, administrative staff and the registered manager. We spoke to two patients who attended the clinic.

Our inspection team

The team that inspected the service comprised of two CQC inspectors. The inspection team was overseen by Judith Connor, Head of Hospital Inspection.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Our rating of safe stayed the same. We rated it as **Good** because:

- The service provided a wide range of mandatory training and had systems in place to ensure this was completed.
- Staff understood their safeguarding responsibilities and information was shared during team meetings and on staff bulletins.
- The service used an electronic system for patient records which meant staff, patients and GPs had access to important information when they needed it.

However,

- The service did not provide a sufficient clean space for cleaning used equipment. This could pose a risk to the spread of infection.
- We observed that the clinical waste bin had not been emptied recently which meant there was an increased risk of infection.
- Paper records were not always completed in line with best practice guidance. This was because entries were not always signed by the person making the entry which was not in line with the Royal College of Physicians record keeping standards 2015.

Good



Are services effective?

Our rating of effective stayed the same. We rated effective as

Requires improvement because:

- The consent policy was not in line with general medical council guidance, putting both patients and staff at risk of not having proper discussions about treatment or documenting consent. We found consent was not being recorded. This meant there was a risk that consent was not always being sought from patients. The service updated their policy immediately following discussion with managers.
- The service did not monitor outcomes of care and treatment.

However,

- The service met its own target of referral to treatment times being within 14 days.
- There were enough staff who were competent in their roles and had good support and mentoring from managers.
- There was good multidisciplinary working between different types of staff.

Requires improvement



Summary of this inspection

Are services caring?

Our rating of caring stayed the same. We rated it as **Good** because:

- Staff treated patients with compassion and patients' dignity and privacy was respected.
- Patients told us that staff were always kind, introduced themselves and were positive in the feedback questionnaires.
- Staff spent time explaining conditions and treatment, and patients knew who to contact if they were concerned or worried.

Good



Are services responsive?

Our rating of responsive stayed the same. We rated responsive as **Good** because:

- The service established good links with the local area to help plan the service to meet the needs of local people.
- The service was pro-active in purchasing a translation telephone service.
- The service used patient feedback to help make improvements.
- The service adapted to meet the needs of individual patients.
- The service had clear admission and exclusion criteria and offered patients an appointment within one to two weeks of referral and patients did not have to wait long in the waiting area.

However,

- The service did not have a system to highlight individual needs such as whether a patient had a sensory impairment or disability. The service was reliant on the GP referral form for information.
- The service had not received any formal complaints in the past 12 months, however, the complaints policy did not specify a timeframe to respond to complaints. This meant there was a risk that complaints may not be responded to without delay.

Good



Are services well-led?

Are rating of well-led stayed the same. We rated well led as **Good** because:

- The service had a clear vision and strategy which staff were aware of and how this fit in with the wider aims.
- The service engaged well with patients and staff and was very responsive to feedback.
- There was a clear governance and management structure. Managers had clear roles and remit and were accountable.

Good



Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	Good	Good	Good	Good	Good
Overall	Good	Requires improvement	Good	Good	Good	Good

Notes

Community health services for adults

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

Are community health services for adults safe?

Good 

Mandatory training

- The service provided mandatory training in key skills to staff and made sure people completed it. The service had recently started using an electronic training management system. The system specified mandatory courses dependent upon role.
- Examples of mandatory training included: infection control, safeguarding adults and children, dementia awareness, basic life support and information governance.
- The training was completed electronically and recorded when individual courses were due and which staff had completed the training. An alert was sent to the manager if staff did not complete their training. The system was easily accessible to staff and staff were allowed enough time to complete.
- We saw compliance rates for individual staff was high. Gaps in compliance was due to a member of staff who was on long term sick leave.
- The service offered face to face training for staff for example in resuscitation on an annual basis.

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.

- The service had a safeguarding policy for adults and children which was based on the local clinical commissioning group safeguarding policy. The policy included information about the different types of safeguarding concerns, however the policy did not direct staff how to make a safeguarding alert.
- We saw a safeguarding flow chart on the wall of the consultation rooms which staff could follow if they had any safeguarding concerns. Staff we spoke to told us they would be able to recognise safeguarding concerns and could describe the process for reporting.
- The clinical commissioning group provided an audit tool for the service to determine how well they were doing regarding their safeguarding responsibilities. This covered questions such as whether the service had a safeguarding lead and the service noted action to take following the audit, for example to include information in staff handbooks. The service met the actions within the audit.
- The manager attended the safeguarding meeting every three months, held with the local authority and clinical commissioning group. The service received safeguarding bulletins which was given to staff via the newsletter and discussed at team meetings. We saw evidence of safeguarding information in the staff newsletter.
- The registered manager was the safeguarding lead. The service provided safeguarding level one and two training for both children's and adult's which was completed electronically. There was full compliance with safeguarding training. The service commenced safeguarding children's training at level three, and one out of the two ear care nurses had recently completed this.

Cleanliness, infection control and hygiene

Community health services for adults

- The service managed some aspects of cleanliness, infection control and hygiene well.
- We found that nasal-endoscopes (equipment which looks at the nasal and sinus passages) were wiped down between use although staff told us they were not deep cleaned. However, following the inspection the service confirmed that equipment is always cleaned with sterile wipes prior to use and decontaminated in line with Highfield's standard operating procedure and the manufacturer's guidelines.
- Staff were aware nasal-endoscopes should be cleaned away from where the procedure occurred to reduce the risk of spread of infection. However, we observed that nasal endoscopes were stored in a box; staff told us this had not always been cleaned in between use. This meant there was an increased risk of contamination and infection.
- We raised this with the manager and following the inspection they told us they had put measures in place to ensure effective storage of equipment in between use. They told us that endoscopes were now stored in a designated container in a clean area of the treatment room. The service purchased a secure storage box which is sealed after full decontamination, so staff know the equipment is safe and ready to use.
- There was a room designated for clinical waste; clinical waste was stored in yellow bags. Although managers told us clinical waste bins were emptied daily, we observed that the clinical waste bin had not been emptied recently which meant there was an increased risk of infection.
- The service had policies to manage cleanliness, infection control and hygiene, including a separate hand washing policy and legionella policy which staff were aware of. Nursing staff were responsible for cleaning of clinical areas and knew the process.
- The service recently commenced monthly infection control audits. We checked the audit for February 2019:
 - hand hygiene: 77%
 - environment: 95%
 - waste: 88%
 - body fluid spills: 100%
 - personal protective equipment: 100%
 - sharps: 93%
 - vaccine storage: 89%
 - specimen handling: 100%
 - minor surgery room audit: 100%
- The service put measures in place to address the lower hand hygiene score, including increasing the number of monthly audits and spot checks.
- Examples of items checked in the audits included 'used instruments are disposed of in the correct manner' and 'hands are decontaminated (appropriately) following the removal of gloves'.
- We observed staff cleaning their hands between patient consultations and the two staff on duty observed the 'bare below the elbows' good practice guidance.
- All areas were visibly clean and tidy. Patients told us the clinic area was always clean and they noticed staff washing their hands. We saw good availability of aprons, gloves, hand gel and sterile wipes for staff to maintain hygiene. Body spill kits were available in all clinical rooms and the reception area.

Environment and equipment

- The service had suitable premises and equipment and looked after them well.
- The layout of the building was accessible; there were disabled accessible toilets, and wheelchair access at the entrance of the building and inside.
- To understand how the service maintained environment and equipment, we checked three consultation rooms, the waiting areas, the equipment cupboard, equipment which looks at nasal and sinus passages (nasal-endoscope), and resuscitation equipment.
- We found that ear, nose and throat workstations for the nasal-endoscopes had been serviced in date. These contained all the necessary equipment for the procedure.
- There was a range of disposable equipment, such as tongue depressors and ear speculums available. We found that disposable equipment and the nasal-endoscope were stored securely. Staff were responsible for ordering new stock when needed. The service completed daily and weekly equipment checks; we saw evidence of these being fully completed during the month of February 2019.
- Sharps boxes were sealed and stored on the shelf of the equipment room. This was in line with the Sharps Instruments in Healthcare Regulations 2013 and the Department of Health and Social Care (DH) Health Technical Memorandum (HTM) 07/01 in relation to the safe management and disposal of healthcare waste.
- We found that the resuscitation equipment had the necessary equipment for both adults and children all of

Community health services for adults

which were in date. Although we did not see completed checklists, the service told us they completed daily checks of the equipment. We saw a full oxygen cylinder, which was in a grab bag with the resuscitation equipment. There were first aid kits and breathing masks which were in date.

Assessing and responding to patient risk

- The acuity of patients referred to the service was very low, and staff did not undertake risk assessments for patients. Staff were reliant on the GP highlighting risks, and the service worked with local GPs to improve the quality of referral information. Managers told us the service had access to a full shared medical record and could accommodate any additional needs of patients.
- Staff had equipment to check pulse rates and blood pressure however usage of this was uncommon.
- All staff were trained in resuscitation and basic life support for adults and children on an annual basis. The service had a member of staff trained in first aid.
- We could not see a policy for transferring patients to the local hospital if they became unwell on the premises. However, staff had good access to GPs as the service was part of the GP federation. Staff could contact a GP if a patient became unwell during their appointment. Staff also knew to contact NHS 111 for advice, or 999 for medical emergencies.
- The service accepted referrals for children. We found the service had access to a paediatric specialist nurse which meant the needs and risks of children could be dealt with if required. This could also reduce hospital admissions.

Staffing

- The service had enough staff to provide the right care and treatment. Staffing levels were planned to allow delivery of the contract with a local NHS trust and meet the needs of patients.
- The service had a stable staffing complement and employed eight members of part time staff: two ear care nurses (both advanced nurse practitioners), health care assistant, administrative staff and operational managers.
- Whilst staff were on annual leave or sick leave the service increased working hours of other staff to avoid cancelled appointments. The service did not use bank or agency staff.

- The service planned to recruit a further ear care nurse to cover leave and help the service manage an increased number of referrals.
- The service offered two consultant led clinics per week. The consultants were employed by the local NHS trust and contracted via a service level agreement, which we saw evidence of. The trust monitored compliance with the contract via a contract monitoring officer who made spot checks to the service.

Records

- Staff kept records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- In September 2018 the service started transferring their paper records onto an electronic recording system; the transfer was on-going at the time of inspection.
- The electronic system was the same used by all GP practices in the area. This meant staff could access records easily at the time of appointment. The patients said their notes were always up to date and available for their appointment.
- Nursing staff documented their consultations on to the electronic recording system and we checked 10 records. All records checked had a copy of the GP referral letter which contained details of allergies. We saw evidence of letters to the patients' GP outlining the outcome of the appointment.
- Records contained details about the equipment used during the appointment where appropriate. The records we checked included information about the patient's condition, the examination, the procedure and any further comments.
- Consultants recorded outcomes of appointments on paper records which were stored securely at the service. The notes were dated however four out of the 10 records checked were not signed to indicate who had seen the patient and made the entry. This was not in line with the Royal College of Physicians record keeping standards 2015. This states that all entries must be signed by the person making the entry.
- Follow up letters were dictated to administrative staff and sent electronically to the GP. The service planned to move towards electronic record keeping for these appointments also and we saw this was a discussion point in team meeting minutes.

Medicines

Community health services for adults

- The service did not use any controlled drugs and staff did not prescribe any medication; prescriptions were completed by the patient's GP if required.
- The service administered ointment or anaesthetic spray for ear, nose and throat procedures and these medicines were stored securely. The service had a standard operating procedure to make sure that medicines were stored properly until the point of use or disposal.
- The medicines management policy made sure that stock was regularly rotated and checked to ensure medicines had not expired. Compliance with the medicines management policy was checked every six months by the operations manager.
- Staff could use ointment for both adults and children. The ointment did not require staff to weigh or measure children to ensure correct dosages.

Incident reporting, learning and improvement

- The service had a system in place to manage patient safety incidents.
- Staff could describe the process for reporting incidents and told us they were encouraged to do so.
- The service had a live document to record incidents including 'what happened' and 'whether any changes made'. Between February 2018 and February 2019 there were 12 incidents reported. We saw evidence these were investigated, and the service recorded what actions were taken.
- The service had a significant event policy for the recording and investigation of incidents. The policy directed staff to complete significant event report forms and analysis forms within one day of the incident. We looked at four forms and found they were completed on the day of the event, in line with policy. They included what immediate actions were taken, follow up actions, degree of harm and duty of candour requirement if required. Duty of Candour is a legal duty on providers to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. The Duty of Candour aims to help patients receive accurate truthful information from health providers. None of the incidents met the Duty of Candour requirements. The requirement for Duty of Candour was outlined in the policy.
- We looked at minutes of team meetings and analysis forms and saw that incidents were discussed with the wider team for action and learning.

- The service was aware of the requirement to notify the Care Quality Commission and other external bodies of notifiable incidents.

Are community health services for adults effective?

(for example, treatment is effective)

Good 

Our rating of effective stayed the same. We rated it as **requires improvement**.

Evidence-based care and treatment

- We found little evidence that the service provided care and treatment based on national guidance such as those by the National Institute for Health and Care Excellence.
- Nursing staff attended conferences specific to the role and participated in ear care forums and relevant networks. Staff could share and discuss best practice at these conferences which was then fed back to the service.
- Staff attended a best practice forum each year to share learning and evidence-based practice. Staff told us any learning was discussed during team meetings.

Nutrition and hydration

- The nature of the service did not require staff to meet patients' nutritional needs. There were water coolers available in the waiting area.

Pain relief

- The nature of the service did not require staff to routinely monitor pain levels of patients.
- Anaesthetic spray was offered to patients when undertaking procedures, providing pain relief for patients.

Patient outcomes

- The service aimed to see patients within two weeks of referral and were achieving this target.

Community health services for adults

- For both ear care, and ear, nose and throat clinics the national target for waiting times from referral to treatment was 18 weeks. The service's own target was within 14 days which they met for the six months prior to the inspection (September 2018 to February 2019).
- The service had recently moved to an electronic recording system which managers said helped them begin to audit the service and make improvements, for example infection control.
- The service sought patient feedback to make improvements.
- The service did not monitor outcomes.

Competent staff

- The service made sure that staff were competent for their roles. Managers completed appraisals every year and we saw that all staff had completed these. Nursing staff were mentored by more senior clinical staff informally on a weekly basis.
- Staff were given protected learning time. The service closed for half a day per quarter to allow staff to complete electronic training and managers identified training gaps. The service funded courses through the clinical team and the board minutes we checked showed evidence of this.
- Staff told us they felt very supported and could seek advice from the GPs and consultants. Staff said they received the right training for the role.
- The service supported a member of staff to complete the nurse prescribing course. They received on-going mentoring and observations to achieve the qualification.
- We found that staff work was overseen and had access to clinical supervision.

Multidisciplinary working and coordinated care pathways

- Staff worked together as a team to benefit patients. The staff within the service included consultants specialising in ear, nose and throat procedures, ear care and audiology nurses and health care assistants. Staff described working well together and could ask for advice when needed.
- The service held multidisciplinary team meetings every one or two months. The consultants were not always present at these meetings due to work load

responsibilities at the trust. We looked at four sets of team meeting minutes and found that all employed staff attended and there was good recording of discussion.

- We found that information from all levels of staff was easily accessible and staff reported being able to refer on to other departments easily. Staff could recommend referrals to other departments via the patients' electronic record, to allow the GP to follow up.
- Managers worked closely with the local NHS trust and clinical commissioning group, and the safeguarding team.

Health promotion

- There were a variety of posters and information leaflets in the waiting area, for example exercise groups, healthy eating and breast cancer awareness.
- Staff could make recommendations for the GP to refer to other health departments.

Consent and Mental Capacity Act.

- The service had a consent policy that stated the clinician must be satisfied patients understood benefits and risks and consented to a procedure. The policy stated that written or verbal consent should be obtained for procedures that carried a substantial risk or for patients under 18 years of age.
- We observed one consultation where a routine procedure was undertaken. The staff explained the procedure to the patient and what to expect, and the patient verbally consented.
- We checked 10 paper records. Seven records indicated that a patient required a procedure using the nasal-endoscope (equipment which looks at nasal and sinus passages). We could not see any written evidence that the patient consented to the procedure. We were not assured that policy and practice reflected General Medical Council guidance: this states clinicians should record their discussion with patients and the decision made.
- We told the service about our concerns and the managers immediately updated their paperwork to ensure recording consent was mandatory. Managers told us that following the inspection they had arranged updates with staff to increase knowledge about recording discussions and consent.

Community health services for adults

- The service had a Mental Capacity Act 2005 section in the overall safeguarding policy which reflected the principals; staff we spoke to were aware of the broad principles of the Mental Capacity Act.

Are community health services for adults caring?

Good 

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

Compassionate care

- Staff cared for patients with compassion during the consultations we observed.
- Feedback showed that patients were treated well and with kindness and that dignity was respected. Patients said that staff always introduced themselves and their confidentiality was maintained.
- We were told that reception staff put patients at ease and helped patients to feel calm. For example, staff spent time talking to patients in distress, booked taxis and accompanied patients to their cars.

Emotional support

- Patients told us that staff involved them and those close to them in decisions about their care and treatment.
- Staff told us that patients thanked staff for their help and support and this could be seen through 'thank you' cards in the reception area.
- The feedback we received from patients included 'I had confidence and trust in the health care person who was treating/advising me'.

Understanding and involvement of patients and those close to them

- Staff provided emotional support to patients to minimise their distress.
- We observed one consultation and found that staff interacted well with patients and took the time to explain the condition and treatment.
- Patients told us they knew who to contact if they were worried, and that staff always explained their condition and treatment.
- One of the patient questionnaires described Highfield ENT Clinic as 'an excellent service', another patient

described as 'a really good service every time'. Patients said they would use the service again and recommend to family and friends in all the 10 questionnaires we checked.

Are community health services for adults responsive to people's needs? (for example, to feedback?)

Good 

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

Planning and delivering services which meet people's needs

- The service planned and provided services in a way that met the needs of local people.
- The service held a contract with the local NHS trust to deliver the ear, nose and throat facility. The service was part of a GP federation. This benefitted the service by having an effective working relationship and communication with local GPs.
- Referral forms had recently been improved to meet the service and GP requirements to ensure they were effective in delivering the care needed.
- In response to patients from outside of the United Kingdom living in the local area, managers invested in a translation telephone line service. This allowed interpreters on the telephone to translate what consultants and nurses said. Patients commented on how helpful this was especially for children.
- The service completed a small audit regarding their signage and made changes in response. The clinic was well signposted with clear signs for car parking. There was ample free parking available which patients commented on positively.
- Patients told us the waiting area was comfortable and they did not have to wait long for their appointment. We saw that patients were seen straight away during the inspection.
- The service had recently invested in a text messaging service to remind patients of their appointment. Patients told us this system worked well and they could cancel the appointment by text message.

Community health services for adults

Meeting the needs of people in vulnerable circumstances

- The service took account of patient's individual needs.
- The service did not have a system to highlight individual needs such as whether a patient had dementia or a learning disability. However they worked with local GP practices to improve the information in GP referral letters so that relevant information was received.
- We saw several examples of how staff took account of individual needs. For example, a patient who had a learning disability found the reception area stressful. In response, staff offered a separate room to wait in and offered the first or last appointment of the day when the clinic would be less busy.
- The service had toys for children to play with in the waiting area and two nurses would accompany children or anxious patients if required.
- Staff attended dementia training to increase awareness and knowledge about how to communicate with patients with a cognitive impairment.
- The service had a chaperone policy and any patient could request a chaperone. The policy stated that children under 18 were automatically chaperoned if they were not accompanied by an adult.

Access to the right care at the right time

- The service was open during the following times:

Mondays: 9.30am to 5pm

Tuesdays: 12.30pm to 8pm

Wednesdays: 9.30am to 5pm

Thursdays: closed

Fridays: 9.30am to 5.30pm.

The service was closed on Saturdays and Sundays.

- The service used a flow chart to make decisions about the correct pathway for the patient. Patients were directed to either the consultant for ear, nose and throat issues, or to the ear care nurse.
- The flow chart also helped staff to make decisions about accepting a patient following referral. For example, patients who were experiencing dizziness and children under two years of age were excluded.

- The service did not have a waiting list and were able to see patients within two weeks of referral. The patients we spoke to told us they were seen within the same week.
- The service provided the following did not attend rates (when patients do not attend their appointment) for 2018. Between July 2018 and December 2018 there had been 120 for ear care and 70 for ear nose and throat appointments.

Ear care:

- July 24
- August 18
- September 19
- October 24
- November 17
- December 18

Ear, nose and throat:

- July 11
- August 16
- September 17
- October 15
- November 5
- December 6

- The service had invested in a text messaging service towards the end of 2018 to remind patients of their appointment two days before. The service also allowed patients to cancel their appointment using text message or via the service website. Information provided by the service showed that there had been a decrease in November 2018 and December 2018 in the number of did not attend rates.

Learning from complaints and concerns

- The service recognised concerns and complaints, investigated them and shared learning with staff.
- The service had a complaints policy and we saw a compliments, comments and complaints box in the waiting area. The service had not received any formal complaints in the past year and patients we spoke to told us they had no complaints about the service.
- The policy did not stipulate a time frame for staff to respond to any complaints by. We communicated this to managers who advised they would amend the policy.

Community health services for adults

Are community health services for adults well-led?

Good 

Our rating of well-led stayed the same. We rated it as **good**.

Leadership of services

- The service had a clear management structure, led by a board of directors. The board of directors were part of the wider GP federation. Within Highfield ENT, management consisted of the hospital operations manager and the service clinical lead.
- We found that managers at all levels were visible within Highfield ENT and we saw effective communication between the managing director, the business manager and staff during the inspection.
- The business manager had been in post for two and a half years and had good understanding about the challenges to quality and sustainability. The business manager had identified challenges using technology and used evidence to secure extra resources to alleviate pressure. For example, securing an operations manager to develop the audit and electronic systems.

Service vision and strategy

- The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients and local community groups.
- The service was involved in the development of the 'One Halton Programme' strategic vision. The aim was to provide an NHS trust level offer in a community setting, and to function as a primary care facility. One way the service achieved this was to bring consultants' expertise from the NHS trust into the clinic.
- Staff we spoke to were aware of and engaged with the vision and strategy.

Culture within the service

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

- Staff told us they felt supported within their roles and there was a positive culture within the service. Staff knew how to raise concerns, as per the significant event policy.
- Staff felt encouraged to attend training courses and engage in professional development for example the nurse prescribing course.

Governance, risk management and quality measurement

- The management structure allowed for clear lines of accountability, functions and remit. Managers were accountable to a board of directors. The service completed pre-employment checks and re-validation checks of staff and were involved in governance meetings with the head of governance for Widnes Highfield Health Ltd every year.
- The service had compliance meetings twice a year with the NHS trust and the service had key performance indicators (targets) to achieve.
- The service contracted two consultants via a service level agreement with the local NHS trust. The service had an arrangement in place for the trust to undertake the governance and human resource function for the consultants and we saw copies of the contracts.
- The business manager, managing director and clinical director met bi-weekly to discuss issues such as patient stories, any concerns, planning, and finance. Minutes were sent to the board and managers met with the board twice a month. The standard agenda items included: the performance report, compliance, governance, human resources, significant events and complaints. Information from meetings was sent to staff via the staff bulletin and discussion at team meetings.
- Although the duty of candour policy stated the relevant person must be informed as soon as possible about an incident, it did not specify this should be within 10 working days, which is a requirement for services provided by an NHS standard contract. The policy did not state that the information about the initial notification should be provided in writing as outlined in legislation.
- The service had systems to identify risks and planned to eliminate or reduce them.
- The service maintained a risk register which included a risk owner, risk rating and actions taken to address. Managers reported the biggest risk was the rate of

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growth balanced with stability of the service. Managers recognised that staff may feel more pressure and overwhelmed. The service addressed this through appointing a supervisor.

- Managers recognised the risk to planning and sustainability resulting from the length of the contract held with the local NHS trust. The service had raised this with commissioners and the contract manager and were looking at extending the contract.
- The service monitored performance through their human resources department and appraisal system. Service performance reports were discussed and noted by the board; we reviewed three sets of board meeting minutes and saw evidence of this.

Public engagement

- The service engaged with patients, to plan and manage appropriate services, and collaborated with partner organisations effectively, as follows:
- The service collected patient feedback through patient engagement forms. Managers asked clinical teams to provide forms for patients to complete. There were feedback boxes in the waiting areas.
- The operations manager collated the paperwork to understand feedback. The service had examples of where changes had been made. This included re-painting white lines in the car park and investing in clear signage as some patients were unsure where to park. The service also invested in water coolers following feedback of patients during hot weather.

Staff engagement

- The service encouraged staff to complete staff surveys and managers analysed feedback following annual appraisals.

- We checked four team meeting minutes and saw staff members could discuss what they thought was working well and what could be improved, with follow on actions noted. Feedback was reported at board level, for example staff concerns regarding increased workloads. Managers responded to staff concerns and secured extra resources to help grow the service.
- Managers told us they sought feedback informally and had an 'open-door' policy. Managers provided staff with information about other services within the GP federation. For example, in team meetings and through the website.

Innovation, improvement and sustainability

- A key aim for the service was to move to a paperless system in line with the wider local general practices. The service was beginning to achieve this through their electronic recording system, website and use of secure email. Managers told us electronic systems brought efficiencies as they no longer used fax or scanning technology.
- The electronic systems allowed the service to collect relevant information, for example patient numbers, demographic and common symptoms to plan for new clinics.
- The service planned to expand the ear clinic function to five days per week, with more consultant led clinics to support the sustainability of the service.
- The service was looking at easing pressure of children arriving at emergency departments for ear, nose and throat problems. For example, by employing specialist nurses to provide dedicated clinics.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The service must ensure that consent is obtained and recorded in line with best practice guidance. This was a breach of regulation 11 (1).

Action the provider **SHOULD** take to improve

- The service should consider updating the complaints policy to include response times to formal complaints.
- The service should amend the Duty of Candour policy to fully reflect legislation.

- The service should consider updating the safeguarding policy to show staff how to raise a safeguarding alert.
- The service should ensure that entries on paper records are always signed.
- The service should ensure a designated clean area for equipment. The service reports they have made the necessary changes however this has not yet been evidenced by us.

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 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 of the Health and Social Care 2008 (regulated Activities) Regulations 2014 Patients were not protected against the risks associated with a lack of recording discussions about procedures and consent because of an ineffective consent policy.
Surgical procedures	
Treatment of disease, disorder or injury	