Chime Social Enterprise

Quality Report

CHIME SOCIAL ENTERPRISE
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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

Overall summary

Chime Social Enterprise provides audiology assessment and treatment for adults, and children and young people. Only audiology services for children were included as part of this inspection as audiology services for adults are not currently required to be registered with the Care Quality Commission. This report includes the community children and young people core service.

The regulated activities are diagnostic and screening procedures and treatment of disease, disorder or injury.

Chime is a community interest company. This means that any surplus of funds is reinvested into the organisation to improve NHS services. Chime has a contract to offer NHS children's audiology services, free at the point of delivery on behalf of NHS Northern, Eastern and Western Devon Clinical Commissioning Group. At the time of our inspection a re-tendering process was underway.

Chime accepts referrals from health, social care or education professionals for children living in Exeter, Mid- and East Devon. It provides detailed hearing assessments, advice and appropriate management of permanent hearing loss. This includes fitting hearing aids and other appropriate listening devices together with specialist advice and information. Chime carries out a variety of different tests, depending on the age and ability of the patient and whether they have any complex hearing problems, including hearing loss and tinnitus. Some children under three years of age are seen as part of the new-born hearing screening programme. Once tests are completed the team make recommendations and provide appropriate treatment. Patients attend the audiology service as outpatients or are seen in their own homes. Staff also visit schools and a community group setting.

During April 2016 to March 2017, Chime carried out a total of 51,689 episodes of care. Of these, 7,216 (14%) were with children and young people.

We regulate this service but we do not currently have a legal duty to rate it. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary. We found the following areas of good practice:

- Staff were confident to identify and report safeguarding concerns.
- Staff knew how to report incidents. There had been prompt investigation and learning from a serious incident that was shared within the team and with other audiology services.
- Facilities were clean and equipment was in calibration and well maintained.

Summary of findings

- There was sufficient staffing and fluctuations in demand were anticipated effectively.
- There was good compliance with mandatory training for safeguarding level two and three and for moving and handling, conflict resolution and prevention of radicalisation training.
- The service had recently been awarded Improving Quality in Physiological Services (IQIPS) accreditation. IQIPS is a professionally led programme with the aim of improving services, care and safety for patients undergoing physiological tests, examinations and procedures.
- All staff were qualified to carry out their role and were given opportunities to develop and share their skills.
- Current evidence based practice was used to develop and deliver treatment. The service used up to date technology to obtain good outcomes for patients.
- Teams worked effectively with other services for the benefit of patient care.
- Patients who moved from children's to adults services were prepared for this transition in a coordinated way. Staff respected the confidentiality of patients and their families.
- Staff involved parents of patients throughout the consultations and provided comprehensive explanations of symptoms and treatment options.
- Information leaflets for patients and their families had been upgraded to explain what to expect from the hearing assessment and how parents could help children to benefit from their audiology treatment.
- Patients were offered appointments at a range of locations including home visits for very young babies.
- When paediatric patients required audiology assessment or intervention, they were assessed within six weeks and treated within 18 weeks. This met the standards set by the clinical commissioning group.
- Staff viewed the leaders of the service as knowledgeable, approachable and supportive.
- Leaders were focussed on the forward vision for the service.
- Staff demonstrated the values of the organisation and were engaged with the service strategy.
- Staff enjoyed their work and were committed to providing effective and patient centred care. Teamwork was valued and nurtured both within the service and with external agencies.

However, we also found the following issues that the service provider needs to improve:

- Not all staff were up to date with mandatory training; in particular there was low compliance with fire safety, infection prevention and control, basic life support and paediatric life support.
- There was a detailed risk register but this did not contain clear arrangements for reducing the impact of risks and timeframes for when this should be completed and by whom.
- There was no documented method by which key safety and quality information was regularly reported on and challenged by the board as part of the board assurance process
- Staff did not always comply with the organisational policy for infection prevention and control
- Staff had not participated in duty of candour training
- In waiting rooms at locality clinics there no toys or diversional activities for children.
- Children were not always encouraged to voice their opinions during audiology appointments
- The provider did not always signpost children and their families to resources for emotional support where applicable
- Patients and their families were not routinely provided with information about how to complain about services

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, to help the service improve. We also issued the provider with two requirement notices that affected the children's services. Details are at the end of the report.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for children, young people and families		• Staff were confident to identify and report safeguarding concerns. • Staff knew how to report incidents. There had been prompt investigation and learning from a serious incident that was shared within the team and with other audiology services. • Facilities were clean and equipment was in calibration and well maintained. • There was sufficient staffing and fluctuations in demand were anticipated effectively. • There was good compliance with mandatory training for safeguarding level two and three and for moving and handling, conflict resolution and prevention of radicalisation training. • The service had recently been awarded Improving Quality in Physiological Services (IQIPS) accreditation. IQIPS is a professionally led programme with the aim of improving services, care and safety for patients undergoing physiological tests, examinations and procedures. • All staff were qualified to carry out their role and were given opportunities to develop and share their skills. • Current evidence based practice was used to develop and deliver treatment. The service used up to date technology to obtain good outcomes for patients. • Teams worked effectively with other services for the benefit of patient care. • Patients who moved from children's to adult services were prepared for this transition in a coordinated way. Staff respected the confidentiality of patients and their families. • Staff involved parents of patients throughout the consultations and provided comprehensive explanations of symptoms and treatment options. • Information leaflets for patients and their families had been upgraded to explain what to expect from the hearing assessment and how parents could help children to benefit from their audiology treatment.

Summary of findings

- Patients were offered appointments at a range of locations including home visits for very young babies.
- When paediatric patients required uni-disciplinary assessment or intervention, such as an audiology assessment or provision of a hearing aid, they were assessed within six weeks and treated within 18 weeks. This met the standards set by the clinical commissioning group.
- Staff viewed the leaders of the service as knowledgeable, approachable and supportive.
- Leaders were focussed on the forward vision for the service.
- Staff demonstrated the values of the organisation in their work and were engaged with the service strategy.
- Staff enjoyed their work and were committed to providing effective and patient centred care. Teamwork was valued and nurtured both within the service and with external agencies.

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- There was no documented method by which key safety and quality information was regularly reported on and challenged by the board as part of the board assurance process
- Staff did not always comply with the organisational policy for infection prevention and control
- Staff had not participated in duty of candour training

- In waiting rooms at locality clinics there no toys or diversional activities for children.
- Children were not always encouraged to voice their opinions during audiology appointments
- The provider did not always signpost children and their families to resources for emotional support where applicable

Summary of findings

- Patients and their families were not routinely provided with information about how to complain about services

Summary of findings

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Services we looked at
Community health services for children, young people and families;

Summary of this inspection

Background to Chime Social Enterprise

Chime is a staff owned social enterprise registered to provide regulated activities of diagnostic and screening procedures plus treatment of disease disorder or injury. At the time of our inspection, Chime was commissioned by Northern, Eastern and Western Devon Clinical Commissioning Group to provide audiology services to adults and children living in Mid Devon, East Devon and Exeter areas. This service includes paediatric hearing testing, fitting, paediatric hearing aid habilitation and rehabilitation and diagnostic follow-up of all babies identified through the New-born Hearing Screening Programme

The audiology service for children and young people is provideded at several different locations including both sites of the local acute hospital, community hospitals, special schools and a parent and toddler group for hearing impaired children. Services are provided on an outpatient basis with some domiciliary visits.

- Chime has been registered with the CQC since 21 March 2011. This service was previously inspected in January 2013 and again in January 2014 and was judged to be compliant in all core standards.
- The registered manager at the time of our inspection, Jonathon Parsons, had been in post since March 2011.

Our inspection team

The inspection was led by : Helen Rawlings – Inspection Manager CQC

The team that inspected the service comprised of one CQC inspector and one specialist advisor; an audiologist.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive independent health inspection programme. The service was not rated as part of this inspection.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information and sought feedback from patients using comments cards

During the inspection visit, the inspection team:

- Visited five locations where audiology clinics for children were being held during the week of our inspection. These included a main hospital site and small community hospital locality clinics. We looked at the quality of the clinic environment and observed how staff were caring for patients.
- Returned for an unannounced visit to the second main hospital site.
- Spoke with four relatives of patients who were using the service.
- Spoke with the registered manager and the clinicians at each of the locations we visited.

Summary of this inspection

- Spoke with other staff members; including administration and reception staff and assistant technical officers.
- Received feedback about the service from one clinical commissioning group.
- Looked at five care and treatment records of patients.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We did not receive any comments cards in relation to this service.

Healthwatch had not received any feedback related to paediatric audiology services.

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?

We found that

- Staff knew how to report incidents. There had been prompt investigation and learning from a serious incident that was shared within the team and with other audiology services.
- Staff were confident to identify and report safeguarding concerns.
- Facilities were clean and equipment was in calibration and well maintained.
- There was sufficient staffing and fluctuations in demand were anticipated effectively.
- There was good compliance with mandatory training for safeguarding level two and three and for moving and handling, conflict resolution and prevention of radicalisation training.

However,

- Many staff were not up to date with mandatory training in fire safety, basic life support and children's life support.
- Operational staff showed very limited understanding of the duty of candour regulations.
- Not all protocols for infection prevention and control were followed consistently by staff.

Are services effective?

We found that:

- Current evidence based practice was used to develop and deliver treatment. The service used up to date technology to obtain good outcomes for patients.
- The service had recently been awarded Improving Quality in Physiological Services (IQIPS) accreditation. IQIPS is a professionally led programme with the aim of improving services, care and safety for patients undergoing physiological tests, examinations and procedures.
- All staff were qualified to carry out their role and were given opportunities to develop and share their skills.
- Teams worked effectively with other services for the benefit of patient care.
- Patients who moved from children's to adults services were prepared for this transition in a coordinated way.

Are services caring?

We found that:

Summary of this inspection

- Staff respected the confidentiality of patients and their families.
- Staff involved parents of patients throughout the consultations and provided comprehensive explanations of symptoms and treatment options.
- When children became distressed, staff adapted their approach and provided reassurance to parents.

However,

- Audiologists did not always support older children to engage in consultations
- Audiologists did not always directly engage in a comforting way with children who became distressed during appointments
- When audiologists identified that a patient had an emotional need, they did not always signpost that child for additional support.

Are services responsive?

We found that:

- Information provided to patients was focussed on the needs of children and their families and presented in a child friendly way.
- Patients were offered appointments at a range of locations including home visits for very young babies.
- When paediatric patients required audiology assessment or intervention, such as provision of a hearing aid, they were assessed within six weeks and treated within 18 weeks. This met the standards set by the clinical commissioning group.

However,

- Patients were not routinely advised how to make a complaint about the service.
- Some clinic waiting areas in community hospital clinics were not equipped with toys or books for children and some clinic areas contained minor hazards for children such as sharp table edges at head height.

Are services well-led?

We found that:

- The oversight of safety and quality were disjointed. Senior clinicians did not regularly report on their specific area of responsibility. There was no regular mechanism by which the board received and challenged reports of safety performance other than when the managing director chose to raise concerns.

Summary of this inspection

- The risk register did not adequately or comprehensively reflect current risks, mitigations, responsibilities or time frames.

However,

- Staff viewed the leaders of the service as knowledgeable, approachable and supportive.
- Leaders were focussed on the forward vision for the service.
- Staff demonstrated the values of the organisation in their work and were engaged with the service strategy.
- Staff enjoyed their work and were committed to providing effective and patient centred care.
- Teamwork was valued and nurtured both within the service and with external agencies.

Community health services for children, young people and families

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are community health services for children, young people and families safe?

Safety performance

- The standard measures of safety performance such as pressure ulcers, falls and urinary tract infections were not relevant to this audiology service. Chime monitored safety parameters such as equipment calibration, mandatory training compliance, safeguarding and infection prevention and control. There were no similar organisations against which Chime could benchmark its performance.

Incident reporting, learning and improvement

- Staff told us they felt confident to report incidents but were rarely required to do so in the paediatric service as very few occured. During the twelve months preceding our inspection, there had been one incident reported in the paediatric service in February 2017.
- At the time of our inspection, this incident was not classified as a serious incident but was classified as an accident. This classification was given based on advice from their clinical commissioning group (CCG) .We reviewed the incident information and following our inspection this incident was reclassified as a serious incident. We asked for assurance that the appropriate investigations would take place following the reclassification, in line with best practice guidance from the National Patient Safety Agency. An update was received and we were satisified the investigation had commenced.
- Considerable effort had been made to manage future risks associated with the incident to prevent it happening again. This included communicating with the manufacturer about a problem associated with custom made paediatric ear moulds so changes could be made, and liaison with regional and national paediatric audiology interest groups to raise awareness of the concern nationally.
- At a department level, details of the incident were emailed to staff immediately and were discussed at the paediatric service team meeting one week after the incident and then at all paediatric team meetings thereafter. The format of the paediatric individual management plan template was amended to include a warning about the risks. Audiologists then highlighted this risk to parents of children who were less than three years of age.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- During our inspection we noted that operational staff and the clinical manager we spoke with were aware of the requirement to be open and honest with patients. However staff did not demonstrate knowledge of the full requirements of duty of candour regulations and did not see this as within their remit of responsibility. They did not participate in specific duty of candour training and at the time of our inspection there was no duty of candour policy. Following our inspection the management team took immediate action to draft and circulate a duty of candour policy.

Safeguarding

- There were reliable systems to ensure that staff had the knowledge and skills to identify safeguarding concerns.

Paediatric staff were trained in safeguarding to level two. Paediatric leads were trained in safeguarding to level three. Staff told us they were able to access advice from a paediatric lead at all times.

- There were reliable systems for staff to report safeguarding concerns. Staff demonstrated understanding of how to identify safeguarding concerns such as neglect. Any concerns were discussed with one of the lead paediatric audiologists and referrals were made directly to the multi-agency safeguarding hub.
- Safeguarding practices were incorporated into administrative protocols. For example, when children did not attend three consecutive appointments, staff raised a safeguarding alert with the local safeguarding hub.
- There was a lack of reliable systems to alert Chime staff to an existing safeguarding or child protection concerns. The patient database did not include an alert to identify if a child had a safeguarding or were under child protection. During the initial interview with the patient, staff asked parents or carers if the child was known to any other health or social care services and relied on this as their source of information. When Chime staff received this information they added it to the patient record as free text. This meant there was potential for staff to not have a comprehensive or accurate understanding of the child's safeguarding needs.
- Chime used a reliable system to improve the likelihood of making safe recruitment decisions and preventing unsuitable people from working with children. Disclosure and barring service checks were completed for all staff employed in the paediatric service

Medicines

- No medicines were used by the provider. There were no medical or non-medical prescribers on the staff team.

Environment and equipment

- The furniture and layout of treatment environments were safe for children. In four of the five locations we visited, the environment was designed to be safe for children, for example table edges were rounded, electrical sockets covered. This was not the case in the fifth location, a community hospital clinic. Staff ensured that children were not left alone and an audiologist was always with the child within clinic rooms.
- In the main hospital site, receptionists were positioned to allow adequate oversight of children and young people in the waiting area. However, this was not consistent in all clinic locations. Waiting rooms in community hospital clinics were not observed by reception staff. This meant that staff relied upon parents or carers to ensure the well-being of patients whilst waiting for their appointments
- The equipment available to children was adequate to keep them safe. For example paediatric resuscitation equipment was available in all clinic locations. However not all staff were up to date with the training needed to ensure they were competent to use the equipment.
- Equipment was maintained and used appropriately. Equipment that came into contact with children was single use and all consumable equipment was in date. All equipment used for testing children's hearing had been calibrated within the 12 months preceding our inspection. All portable electrical equipment had been tested for safety during the 12 months preceding our inspection.
- Staff followed safe systems and protocols for disposal of waste. For example, clinical waste was segregated and bins were not overflowing.

Quality of records

- Individual care records were written and managed in a way that kept people safe. We reviewed five patient records and saw that records were accurate, complete, legible, and up to date. Staff stored all records securely on the electronic drive, and did not use paper records; this meant that records were easily accessible for clinics and always available when required.
- Records were audited to check the quality of record keeping. During 2016, a documentation audit was completed which looked at seven random sets of records from 10 staff. In total 70 records were reviewed. The audit showed some records had information missing and these concerns were clearly identified and discussed at staff meetings to ensure improvements were made.

Cleanliness, infection control and hygiene

- The clinic environments were visibly clean and staff decontaminated equipment prior to patient use.
- Staff did not consistently follow protocols for infection prevention and control. There was an increased risk of healthcare related infections because staff did not comply with the organisational uniform policy. For example, during patient consultations we observed one

clinical member of staff wearing chipped nail varnish on both days we visited, and one clinical member of staff wore sleeves below their elbow. We observed eight patient appointments. None of the audiologists decontaminated their keyboard and mouse between appointments. Computers were not fitted with wipe clean keyboards.

- The service had taken some action to improve compliance with infection prevention and control. An audit of treatment protocols was carried in 2016. Senior staff observed audiologists carrying out treatment. This identified concerns regarding infection prevention and control and as a result further training in local infection control processes was given at a staff training day in March 2017 and reminder notices were placed in all clinic rooms.

Mandatory training

- Not all staff were up to date with essential training for safety systems, processes and practices. At the time of our inspection, not all staff had completed their mandatory training within the twelve months preceding our inspection. For example, less than 30% of staff had completed fire safety training, less than 50% of staff had completed basic life support, less than 60% of staff had completed children's life support, and less than 70% of staff had completed training in infection prevention and control. There had been some delay in provision of training due to a change of supplier. Following the inspection we were provided with evidence that future attendance had been arranged for some of these staff.
- However, compliance with other training such as safeguarding level two and three, moving and handling and prevention of violent extremism (PREVENT) training were all 100% and compliance with conflict resolution training was 94%.

Assessing and responding to patient risk

- Staff used available information to assess and respond to patient risk. Prior to the appointment, audiologists were reliant on the information in the referral letter to identify risks as they were unable to access information from other health or social care providers. During the appointment, staff asked parents about the child's health and involvement of other services in order to identify known risk factors and flagged these on the patient record where necessary. Staff took care to ensure that patient details held on the patient record were correct.
- Staff told us that they were rarely required to respond to high risk situations. Staff were aware how to respond appropriately when children's health and well-being deteriorated. However staff we spoke with had not experienced this situation. In emergency situations, staff knew to telephone for an ambulance.
- All staff were aware of techniques to resolve conflicts. All staff had been issued with a personal alarm.

Staffing levels and caseload

- The paediatric audiology service had the correct number of staff, with the right skills, to deliver safe care and treatment at all times. At the time of our inspection there were 56 members of staff employed by Chime Social Enterprise. These included audiologists, assistant technical officers, and administrative staff. There were six audiologists plus two team lead audiologists who worked primarily in the paediatric service. Two of the paediatric audiologists were on maternity leave at the time of our inspection. Several other members of staff were involved in the service to a lesser extent, such as booking appointments, taking calls, repairing hearing aids, assisting in consultations.
- Leaders of the paediatric service responded proactively to anticipate changes to staffing requirements. There were no vacancies in the paediatric audiology team but there were two members of staff on maternity leave. Leaders had anticipated the need for maternity leave cover prior to their absence and to bridge this gap senior audiologists were training less experienced audiologists to act as assistants in paediatric clinics.
- Patients received continuity of care because there were systems in place to cover staff absence. Many staff were part time and some worked full time hours over four days. This meant that several staff were available to cover at short notice for enhanced pay on their days off. The service did not use any agency or bank staff.

Managing anticipated risks

- Potential risks were taken into account when planning services. Administrative staff who scheduled patients planned for fluctuations in demand for the paediatric

service. For example, there was high demand for patients with 'glue ear' during colder weather and lower demand on the paediatric service during school holidays.

Are community health services for children, young people and families effective?

(for example, treatment is effective)

Evidence based care and treatment

- Current evidence based guidance and standards were used to develop and deliver treatment. For example, special interest groups such as the bone anchored hearing aid group met regularly to discuss new developments or changes to practice.
- The managing director informed audiologists when relevant clinical guidance was published. Protocols were put in place that reflected evidence based practice. These were available for staff to access electronically from all clinic locations. The paediatric audiology service reviewed protocols in line with best practice as discussed at the paediatric audiology interest group. For example, Chime had changed the protocol for conducting visual reinforcement audiometry (VRA) for infants to include use of a different method of interaction and a more simple recording method. VRA is a test that allows an audiologist to assess hearing in infants and toddlers too young for normal tests. VRA uses behavioural conditioning to train very young children to respond to sounds.

Technology and telemedicine

- The paediatric service was using up to date technology to enhance the delivery of accurate and effective assessment and treatment of children's hearing impairment. For example, working in pairs, audiologists used visual reinforced audiometry with puppet boxes to gain the attention of young children to effectively establish hearing thresholds. The service was in the process of installing visual display unit screens to add to and/or replace the puppet boxes. This meant that audiologists had a more flexible range of treatment options available to meet the individual needs of patients.

Patient outcomes

- Information about patient outcomes was collected and monitored and used to make improvements. The paediatric team conducted an audit of the service provision to children aged over three who had their appointments at locality clinics. Recommendations identified from this audit had been discussed with the wider team and in some instances actions completed. For example, plans were in place to upgrade facilities to include visual reinforcement audiometry at the locality clinics. The paediatric service completed a clinical audit of services in August 2016. This report identified several areas for service improvement and action had been taken to address these. For example changes had been made to the booking process to ensure all hearing aids were fitted within four weeks of diagnosis.
- The service participated in accreditation schemes. In 2015, Chime was granted United Kingdom Accreditation Service (UKAS) accreditation against the Improving Quality in Physiological Services (IQIPS) standard for its full range of adult and children's hearing services. Chime was reaccredited in June 2017. The IQIPS scheme is a professionally led assessment and accreditation programme that is designed to help healthcare organisations ensure that patients receive consistently high quality services, tests, examinations and procedures delivered by competent staff working in safe environments. IQIPS accreditation was a contract requirement for all audiology contracts commissioned by the clinical commissioning group.
- The service participated in regional audits and benchmarking projects. In November 2016, Chime published the paediatric audiology report for Devon and Cornwall in collaboration with four acute trusts. This presented the results of a joint retrospective audit of quality measured against standards identified in the New-born Hearing Screening Programme (NHSP). This report was circulated to staff. Some of these actions had been taken forward, for example the requirement for information to be provided for patients and parents.
- The service participated in peer review. Chime Social Enterprise was part of the South West Paediatric Audiology Interest Group. As part of this group, the paediatric audiology service participated in monthly peer review of all new-born hearing screening programmes Auditory Brainstem Response (ABR) tests. ABR tests give information about the inner ear and brain

pathways for hearing. The peer review process provided assurance of the quality of the ABR tests as measured against national standards set by the new-born hearing screening programme
- There is a national expectation that regional paediatric audiology services report on the quality of their service in a number of aspects. The Devon and Cornwall paediatric audiology interest group (PAIG) had agreed a common set of reporting standards against which all services audited their records. These results then combined to create an annual regional hearing services audit.

Competent staff

- All staff had the relevant skills and competencies to treat patients safely and effectively. The assessment and treatment skills of all paediatric audiologists were observed by a senior clinician once per year. Paediatric audiologists frequently worked alongside clinicians of a higher grade and this was seen as a positive learning opportunity. When staff were underperforming, bespoke coaching was delivered to meet their needs, for example, communication skills training.
- Staff were given adequate support when they started their employment. Staff who were on a substantive or fixed term contract attended a corporate induction within 12 weeks of starting employment and participated in a workplace induction facilitated by their manager within eight weeks of starting employment. At the time of our inspection, there was a 97% compliance with completion of appraisals.
- All staff were suitably qualified to carry out their role. Some staff had undertaken additional post graduate training to extend their specialist knowledge. An audiologist from Chime Social Enterprise was taking part in the NHS Scientist Training Programme (STP). The STP is a postgraduate training programme providing an accredited MSc in Clinical Science that leads to eligibility to apply for clinical scientist status. Two of the six senior paediatric audiologists had undertaken study at masters' level as recommended in British Association of Audiology scope of practice for career level six.
- Staff were given opportunities to develop their expertise. The service had approved funding for a range of external courses during the twelve months preceding our inspection. These included administrative, clinical and managerial/business courses. Senior audiologists had a specialist area of expertise, for example tinnitus, or bone anchored hearing aids. There were plans for audiology technical officers to develop skills to take ear mould impressions.
- All staff were invited to an internal study day every three months during working hours that included a staff meeting plus training sessions. No staff were required to run clinics during this time except for a small team who took turns to support the ear nose and throat clinic and the repair service. This forum was also used to share knowledge via a presentation of case studies.
- Audiologists shared their knowledge with other teams. A senior audiologist had provided training regarding the Auditory Brainstem Response (ABR) audiometry test to the local neonatal unit of an acute trust. ABR is a neurologic test of auditory brainstem function in response to auditory (click) stimuli. Two audiologists had presented at a regional conference regarding the implementation of the transition service.

Multi-disciplinary working and coordinated care pathways

- The audiology team worked with other services in a coordinated way. The clinical commissioning group reported that Chime was committed to working with the wider audiology network, nationally and locally. Lead audiologists from Chime attended the Children's Hearing Services Working Group (CHSWG). This was a regional multi-disciplinary forum including representatives from health, social care, charities and patients who worked together to make sure that deaf children and their families had good quality local support which met their needs.
- Where appropriate, staff involved teams from other services to assess and plan and deliver patient care. For example, staff worked with the Exeter Deaf Academy to facilitate effective communication between the two services and to ensure that children attending the school were provided with timely and effective audiological care. Paediatric audiologists regularly visited three schools for children with special needs in order to assess new intakes of students and follow up the needs of children known to the service.
- Audiologists at Chime communicated effectively with the wider multi-disciplinary team. With parents' permission, a copy of the patient's individual management plan was sent to external agencies where appropriate, such as an advisory service for hearing

impaired children and a regional careers service for children moving from children's to adults services. Paediatric audiologists contributed reports to multidisciplinary meetings regarding specific patients.

- There were multi-disciplinary care pathways. For example audiologists contributed to the glue ear pathway in conjunction with the ear, nose and throat team at a local acute hospital. The paediatric audiology service provided annual reviews for patients with chronic conditions such as cystic fibrosis, visual impairment, downs syndrome and cleft palette.
- In 2016, Chime was a case study of good practice in the NHS England commissioning framework for services for people with hearing loss. It was recognised as a fully integrated specialist hearing care service that also supported the wider network in which it was positioned.
- In the survey of children's services completed in March and April 2017, all patients said they felt there had been appropriate involvement of other services in their care where appropriate

Referral, transfer, discharge and transition

- Staff worked together to assess and plan on-going care and treatment in a timely way. Patients who were due to move from children's to adult services were prepared for this transition in a coordinated and seamless way. There was a policy, pathway and protocol to support these patients and this was regularly discussed at the children's hearing services working group. The paediatric team were planning improvements to this service to increase uptake, including starting the process earlier, i.e. in year seven, using activity booklets to encourage engagement of young people.
- Audiologists referred to other services where appropriate, such as the ear nose and throat specialists at the local acute trust. The process of referral onwards was streamlined to avoid delays. Audiologists working in locality clinics emailed referrals to the central administration team who immediately printed them off and forwarded to the relevant department.

Access to information

- All clinical audiology information needed to deliver effective on-going care and treatment for patients was available to staff. The paediatric audiology service used a comprehensive clinic management solution designed specifically for audiology clinics. This included patient demographics, test results, hearing aid programming, appointments and all other documentation. Using their self-managed server and computers, staff were able to access the necessary information from all clinic locations.
- However, the systems that managed information did not support audiologists at Chime to view information systems outside of their organisation. This meant that important background information was not always available in advance of initial appointments. For example, staff were not always aware of child protection orders unless this information was provided at referral or volunteered by families during the consultation. Staff attempted to mitigate this by asking parents/carers if the child was known to other health and social care services.
- There were systems to flag on records where a child had particular needs. These 'flags' did not include child protection orders, learning disability or complex needs, but relevant information was included as a journal entry. Staff told us that they planned all appointments with the expectation that the child may have a learning disability or complex needs as this was often the reality for patients with hearing loss.
- There were systems in place to enable audiologists to share information with other professionals involved in patients care. Staff shared details of attendance and outcome with GPs, school nurses, health visitors for example in the form of an individual management plan. The service encouraged the use of personal child health records ('red books') as recommended by the Royal College of Paediatrics and Child Health. The Personal Child Health Record is a national standard health and development record given to parents/carers at a child's birth and is the main record of the child's health and development. The record is retained by the parent/carer and health professionals should update the record each time the child is seen in a healthcare setting.

Consent

- Audiologists had a practical understanding of the consent and decision making requirements of legislation. Staff enabled parents and young people to give informed consent. We saw that audiologists explained assessment and treatment procedures with patients and families during their consultations
- Audiologists accepted that continued consent was granted because all parties, i.e. patients, parents and carers, engaged in the process of assessment and

treatment. Audiologists did not proceed with assessments and interventions unless children and their carers were fully engaged with the process. Staff we spoke with had never been required to make a decision to assess or to treat without the parent or young persons consent. There was a checkbox document available to staff to help them to assess Gillick competence if required.

- Some aspects of consent were recorded explicitly using specific consent forms, such as permission to share information, or permission to commence on a specific treatment pathway such as the auditory processing pathway. However, for routine assessments and treatments, explicit consent was not formally signed by the responsible adult. Instead, parents or carers gave verbal consent which audiologists recorded in the patient record.

Are community health services for children, young people and families caring?

Compassionate care

- Staff interactions with patients were encouraging, sensitive and considerate. Staff spoke calmly and softly to small children and used a friendly approach to put the children at ease.
- In a patient satisfaction survey completed for the children's service in March and April 2017, all patients were satisfied with the welcome they received at the clinics and with the professionalism of the reception staff and audiologists. All patients said that audiologists were approachable and they were given opportunities to discuss problems or difficulties.
- Staff respected confidentiality at all times. Staff closed clinic room doors during consultations and did not leave computer screens unattended.

Understanding and involvement of patients and those close to them

- During our inspection we saw that parents and carers were always involved in consultations with audiologists. Parents were asked to expand upon the information within the patient referral and asked to describe the child's hearing difficulties from their perspective.
- In six of the eight consultations we observed, staff directly engaged with children and offered opportunity for children to give information regarding their perspective of their condition. In two of the consultations we observed that a member of staff focussed entirely on the adult carer accompanying the child. This meant that during those encounters the child was not encouraged to be an active partner in the assessment and treatment process.
- Older children were offered support to manage their own condition as they made the transition from children's to adult services.
- In a patient satisfaction survey completed for the children's service in March and April 2017, all patients were satisfied with the explanations given to them by audiologists. All patients were happy with their experience of communicating with the service.

Emotional support

- Staff did not always provide comfort to children who were distressed during their consultations with audiologists. In two of the eight consultations we observed, children became distressed during their appointment. In one of these, staff directly engaged with the child and offered comfort to the child when they became tearful. In the other consultation, we observed a member of staff did not offer comfort to the child.
- In all the consultations we observed, staff offered reassurance to their carers. Audiology staff were heard to be supportive towards parents on the telephone who were anxious regarding appointments they were unable to keep for their children.
- For younger children, a member of staff coordinated the Happy Hands support group which provided opportunity for children and parents and grandparents to meet together to learn sign language, learn songs and have new ear mould impressions made.
- Staff showed understanding of the short-term anxieties and forms of distress that children and families might experience when attending the audiology appointment. Staff were aware of the complex factors that affected children's experience of hearing loss.
- In one of the eight consultations we observed, an audiologist treated an older child who presented with complex emotional needs. That member of staff agreed that the child may benefit from professional support for this emotional need. However that member of staff did

not raise this with the patient or their family during the consultation. Staff we spoke with were unclear about who they might signpost patients to for emotional support.

Are community health services for children, young people and families responsive to people's needs?

(for example, to feedback?)

Planning and delivering services which meet people's needs

- The services provided by Chime reflected the geographical spread of the population it served. Audiologists ran clinics from 14 sites located in the local acute hospital sites, several small community hospitals plus three schools and a baby and toddler group.
- The facilities available at clinic locations varied in their suitability for children. These premises were leased from other providers. At the main clinic location, Chime Social Enterprise had access to the paediatric outpatient service waiting room of the local acute trust where a separate play area was available for children. However, waiting rooms in the locality clinics were multi-purpose and did not contain any toys or books for children.
- The facilities available at clinic locations varied in their suitability for audiology testing and treatment. We saw that clinic rooms at the main acute hospital site were well insulated from sound. Clinic rooms at the locality clinics were double glazed and had secondary glazing, however external noises such as banging doors were evident during some hearing assessments. Leaders were aware of the variability in ambient noise levels at locality clinics which may have affected the quality of hearing test results obtained. The need for staff guidance regarding how to measure and mitigate this was raised in a recent IQIPS inspection. Plans to address this were on hold during the tendering process.
- The facilities available at the clinic locations we visited were suitable for people with mobility impairment. We saw that clinics were accessible for patients using wheelchairs and there was sufficient car parking available at the majority of the sites we visited.
- Patients were satisfied with the facilities available to them at clinic locations. In the patient survey of the paediatric service carried out in March and April 2017, all patients were satisfied with the comfort of the clinic rooms, 94% of patients were satisfied with the child friendliness of the waiting areas, 96% of patients were satisfied with the accessibility of the clinic from their home. All patients were satisfied with the signs directing them to the audiology service.
- Where possible, audiologists brought the service to familiar settings where patients and carers were comfortable. For example, a member of staff coordinated the 'Happy hands' support group where
- Audiologists worked together to meet the individual needs of children. For example, when children struggled to participate in formal assessments, they were re-booked for an appointment with two audiologists, allowing one to focus on the needs of the child whilst the other performed test procedures. Audiologists adapted their approach to meet the needs of different age groups.
- When children's needs were not being met, this was identified and used to develop the service. For example the paediatric team had upgraded their information service to meet the needs of families. In November 2016, the Devon and Cornwall paediatric audiology report identified that parents and patients were not given sufficient information. The paediatric team had responded positively to this finding and had put together useful information to help parents and children to get the most from their assessment and treatment experience. This included a patient information leaflet designed specifically for children to describe what to expect during a hearing test and an information pack for children diagnosed with permanent hearing impairment. Audiologists included relevant information in the management plans that were sent to families after their consultations.

Equality and diversity

- Staff ensured that all patients had equal access to care and treatment. For example, when a patients language was a barrier to engagement in the assessment or treatment process, administrative staff contacted interpreting services and arranged for interpreters to be available for appointments when necessary. For patients who needed assistance to express their views, staff enabled patients to access advocates when required.

- Chime had not yet focussed due attention to the workforce race equality standard which brings together organisations to provide leadership on equality and inclusion. The organisation reported on the workforce race equality standard indicators for the first time in May 2017. Prior to this date the clinical commissioning group had not required this information to be submitted as part of their contract. Of the 57 members of staff employed at Chime, 9% described themselves as Black or minority ethnicity (BME). These included 17% of staff at band six and 42% of staff at band 5 level. In the two years preceding our inspection, Chime had recruited staff from overseas to fill audiology vacancies. At the time of our inspection an action plan was not formulated.
- Staff were not routinely asked whether they felt they were offered equal opportunities for career progression, however a higher percentage of BME staff (60%) were offered non-mandatory training than non BME staff (35%). There had been no reported incidences of discrimination or harassment from staff during the twelve months preceding our inspection.

Meeting the needs of people in vulnerable circumstances

- The service was flexible in its approach to delivery of care. The paediatric team delivered the service at a range of locations and situations to reach out to those patients who might struggle to attend regular hospital appointments. This included domiciliary visits to very young babies.
- The paediatric team recognised that young teenagers may disengage with the service at a time when they most needed support to plan for their future as a person with permanent hearing loss. For this reason the transition service had a plan to reach out to young people earlier in order to encourage a two-way engagement with the adjustment process.

Access to the right care at the right time

- The paediatric service offered flexibility regarding choice of appointments. Appointments were rearranged when families could not accommodate prior commitments. There were out of school hours and Saturday clinic slots available. When necessary, children were prioritised and offered urgent appointments if specially requested by the referrer.
- Effort was made to minimise the time people had to wait for treatment or care. Chime offered a drop in clinic for hearing aid repairs. Parents could access this without an appointment and without the need for children to attend if they were at school. In the 2017 survey of the paediatric service, all patients were satisfied with the hearing aid repair and battery replacement service.
- There was an easy–to-use appointments system. When families telephoned with general enquiries or to change appointments, their call was placed in a queueing system and promptly answered. There were two telephone lines manned during working hours by a team of administrative staff.
- At the time of our inspection, the majority of patients had timely access to an initial audiology assessment and subsequent treatment. There had been no breaches of waiting time standards expected by the clinical commissioning group, for example all children had been treated within 18 weeks of referral. In the patient survey conducted in March and April 2017, 98% of patients were satisfied with the time that the child waited to be allocated an appointment.
- In some instances, effective action had been taken to address previous delays to treatment. For example, in August 2016, a clinical audit of the paediatric audiology service reported that only 58% of patients were fitted with a hearing aid within four weeks of diagnosis. Administrative staff now ensured that assessment appointments and fitting appointments were booked concurrently upon receipt of the referral to avoid delay. This had resulted in a clear improvement in response times and since October 2016; all patients were fitted with a hearing aid within four weeks of diagnosis.
- The paediatric service was not reaching all children who needed audiology services. A high percentage of patients did not attend their planned appointments. In May 2017, 12% of patients missed their initial assessment appointment, 36% missed their paediatric visual reinforcement audiometry appointments, and 29% missed their pre-reassessment appointments.
- Action was taken to address the rate of non-attendance. Administrative staff sent text reminders prior to appointments and sent pre-appointment letters for longer appointments. To encourage re-attendance, staff informed referrers and sent follow up letters to families when children missed an appointment.

Learning from complaints and concerns

Community health services for children, young people and families

- There was a low rate of complaints. In the twelve months preceding our inspection there had been one complaint regarding the children's audiology services.
- When complaints were received, the paediatric team responded effectively and there was organisation learning as a result. Following the complaint, Chime reviewed and amended their procedure for sending letters to patients who did not attend their appointment.
- Parents we spoke with were not aware how to make a complaint about the service. Information about how to complain was not routinely sent to patients and their families prior to or after their appointment. This meant that the service was missing an opportunity to gain feedback on the quality of the service.
- However, there was a child friendly comments process available at the main hospital clinics. Patients could choose from three postcards depicting emoticon faces to write on and post in a comments box in the waiting area.

Are community health services for children, young people and families well-led?

Leadership of this service

- Leaders had the capacity, capability and experience to effectively lead .Two lead audiologists were responsible for a clinical caseload plus the day to day running of the paediatric audiology service and the line management of the six audiologists in the paediatric team. The deputy clinical director had a clinical role and was the line manager for the two lead audiologists. The deputy clinical director reported to the managing director.
- Staff were able to approach leaders and leaders were visible at the frontline of service delivery. The managing director also worked as a clinical consultant in the adult's service one or two times per week and the deputy clinical director worked regularly in a clinical capacity.
- When spoken to, leaders at all levels could give examples of challenges to good quality care. The managing director and the deputy clinical director attended band seven meetings where operational concerns were discussed.
- Leaders encouraged appreciative and supportive relationships amongst the teams. Staff told us they felt comfortable to approach leaders of the service to discuss concerns. Less experienced staff consulted more experienced staff for clinical advice.
- In the most recent staff survey completed in January 2016, 87.2% of staff felt their immediate line manager was effective and 87.2% of staff felt their immediate line manager was approachable.

Service vision and strategy

- There was a clear vision and set of values. Chime described its values as 'professional', 'caring', 'committed', 'united' and 'pioneers'. Although staff were unable to list these values, we saw that these values were evident in their work.
- Chime was in the process of tendering for a renewal of their contract for audiology services with the clinical commissioning group. The managing director had a clear vision of how to ensure the sustainability of regional audiology services and was fully involved in engaging with commissioners and other providers to secure this vision. Much of the vision for the service was dependent upon the future shape of the service commissioned.
- All grades of staff were committed to moving the service forward. There were several improvement projects underway in frontline services that continued irrespective of uncertainties regarding the future contract

Governance, risk management and quality measurement

- There was not an effective governance framework to support the delivery of the strategy and good quality care. The oversight of quality and safety was not joined up.
- Senior audiologists retained individual oversight of some aspects of service provision, such as response times, compliance with mandatory training, audit, health and safety. These staff met regularly with the deputy clinical director and the managing director to discuss operational issues. We saw in the minutes from senior audiologists meetings (known as band seven meetings) that safety and quality concerns were discussed, however this did not include regular reporting from senior clinicians regarding their specific areas of responsibility. This meant that not all of the

senior clinicians and the management team were fully briefed regarding clinical governance.For example, the minutes of these meetings showed no evidence of discussion of the non-compliance with mandatory training.

- The managing director monitored data to anticipate potential breaches of waiting times. Data in relation to patient outcomes in the children's service was reported to the clinical commissioning group every three months.
- The board consisted of the chair, managing director, finance director, and four non-executive directors that included a staff council representative and a patient representative, a GP and a marketing and business development advisor.
- There was not a comprehensive assurance system at board level. In the twelve months preceding the inspection, the minutes of the board meetings contained reference to clinical and quality issues raised by the managing director, such as the outcomes of complaints, breaches to the response times, future accreditation inspections, risks identified to patients with pacemakers. However, there was no standard agenda item for patient safety at the board meeting. This meant there was no guarantee that clinical and quality issues would be considered or that the board would receive reports of safety performance, other than if the managing director chose to raise issues or if the board asked for specific information.
- Poor compliance with mandatory training had not been highlighted by senior audiologists at the band seven meeting, senior managers had not identified this as a safety concern and subsequently the issue had not been raised at board level. This meant there was potential for safety concerns to remain undetected and unchallenged.
- There was a detailed risk register but this did not contain clear arrangements reducing the impact of risks and timeframes for when this should be completed and by whom. The risk register contained 74 risks; nine of these risks were rated red. These included risk of eviction with high costs of relocation, lack of a contingency plan for absence of key senior staff, robustness of income with one major contract, insensitive handling of press invitations, stress on finances as a result of high growth, changes in expectations of the service with regard to political change, the need to maximise the Chime Social Enterprise brand. However, there were omissions in this document. The risk register did not identify clear action plans, lead person responsible for ensuring risks were managed, dates for completion or sources of assurance.
- The risk register did not include reference to the issues identified by senior staff at the time of the inspection, for example it did not refer to poor compliance with mandatory training. We did not see evidence that the risk register was used as a working document and/or reviewed regularly by the management team or the board.

Culture within this service

- Staff felt respected and valued. In the most recent staff survey completed in January 2016, 92% of staff felt that the organisation treated them with fairness and respect.
- The culture of the organisation was centred on the needs and experience of patients. Staff we spoke with told us they were given the time and resources to provide a high quality service for children and parents/carers. Staff said they were proud to work for Chime.
- We saw that staff valued teamwork and told us how they benefitted from the experience of other audiologists in their team. The paediatric team collaborated to improve service performance. For example, at the time of our inspection, the team was working on the development of a patient satisfaction questionnaire. All staff were invited to an annual away day to encourage team building and bonding.
- The safety and well-being of staff was promoted. Staff were sometimes required to work remotely either in community hospital clinics or when carrying out domiciliary visits. Systems were in place to support lone working.
- Chime had been awarded the social enterprise mark. This is an accreditation that recognises characteristics of the business model as ethical, credible and commercial.

Public engagement

- The views and experiences of parents and other professionals were gathered and acted upon to shape and improve the service. A member of staff from Chime attended inter-agency children's hearing aid services working group (CHSWG). This was a group of health, education and social care professionals, parents and

voluntary sector. This group worked together to agreed terms of reference to improve services for deaf and hearing impaired children and their families in the area, and encouraged user feedback via online forums.

- To some extent, patient representatives were actively engaged and involved in decision making. There was an adult patient representative on the board of non-executive directors. A patient user group in adult services was consulted regarding changes to protocols such as the revision of the letter sent to patients who did not attend appointments.

Staff engagement

- Staff were involved in making decisions that affected the future of the company. There was a staff council. This consisted of six staff representatives and the group met with the managing director present every two months. This council had clearly defined terms of reference. Representatives from each staff group were voted onto the council by employees. We saw that the staff council ensured that the voice of the employees was listened to. For example, the staff council were reviewing the question format of the staff survey to ensure that subsequent surveys reflected the needs of staff correctly.
- There were adequate forums for staff to engage with the management team. Staff told us they were fully informed regarding the vision of the service. All staff were invited to attend a staff meeting every three months, where operational concerns and updates were discussed. An online question and answer session 'Question Chime' was facilitated every two months; however not all staff we spoke with were aware of this.
- There were some themes of concern that arose from the staff survey conducted in January 2016. For example, 38% of staff stated that morale was not high, 12.8% of staff felt that their views were not listened to, 38.5% of staff stated that they had not received useful feedback on their performance, 20.5% of staff stated that their working environment did not allow them to complete their work effectively, 35.9% of staff said there were not opportunities for personal development, 29% of staff felt that the organisation was not united, 30.8% of staff admitted to being stressed at work and 18.9% of staff said it was not safe to challenge the ways things were done within the organisation.
- Action was taken as a result of the staff engagement. For example, following the staff survey the senior audiologists had attended management training to support their development.
- At the time of our inspection, the format of the staff survey was under review. A staff survey had been completed sixteen months prior to our inspection and there were plans to repeat the survey following our inspection.

Innovation, improvement and sustainability

- Clinicians showed creativity in their approach to improving the service for children and young people. For example, the team planned to produce a video for the website to show what to expect during audiology appointments. The team supporting children to transition to adult services were designing an activity booklet for school children aged 12 and 13 to encourage them to engage with the support and transition resources available to them.
- Despite financial pressures, leaders were focussed on continually improving the quality and responsiveness of the service offered to children. A business case had been submitted to equip three community locality clinics with visual reinforcement audiometry equipment and facilities.
- Chime Social Enterprise had been recognised locally for its innovation. Chime was shortlisted in the 'health' category for the Exeter Living Awards which celebrate innovative business and enterprise in Exeter.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Ensure that all staff are appropriately trained to undertake their roles. This includes meeting the organisational target for mandatory training
- Ensure that the risk register is complete and used to reflect and manage live risks
- Ensure that the board is cited on key quality and safety information in order to assure themselves of the quality and safety of the services they are providing

Action the provider SHOULD take to improve

- Put systems in place to meet statutory requirements including the duty of candour regulations and the workforce race equality standard
- Put systems in place to ensure that staff consistently follow the protocols for infection prevention and control
- Mitigate where possible the environmental risks of all locality clinic rooms in relation to child safety, for example table corners, plug sockets
- Consider providing diversional toys/activities for children in waiting rooms at locality clinics.
- Encourage children whenever possible to participate in consultations during appointments
- Signpost children and families to resources for emotional support where applicable
- Consider methods by which children can offer feedback regarding service delivery and direction
- Routinely provide patients and their families with information about how to complain about services

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
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17 (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. Not all systems and processes were fully established and operated effectively to ensure compliance with good governance. The processes for monitoring quality and safety information were not robust. At operational level, regular reports on quality and safety metrics were not regularly presented to the senior management team. There was insufficient assurance of clinical governance at board level. The risk register was not adequately maintained to provide comprehensive identification of current risks and their mitigation. Quality and safety information was not regularly reported on or challenged at board level. This was a breach of regulation 17 (1)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (2) (c) Care and treatment must be provided in a safe way for service users. The registered person must ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.

This section is primarily information for the provider

Requirement notices

The provider had not ensured that all staff providing care and treatment to patients had received essential mandatory training with regards to fire safety, basic life support, children's life support, infection prevention and control.

This was a breach of regulation 12 (2) c.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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