

Lymphoedema Specialist Services Limited

1-288059235

Lymphoedema Specialist Services Ltd

Quality Report

142, Cherry Garden Road,
Eastbourne
East Sussex
BN20 8HG
Tel: 01323 639911
Website:

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
1-288059235	Station Plaza Health Centre – Hastings	Lymphoedema Specialist Services Ltd	TN34 1BA
1-540811050	Harbour Medical Practice – Eastbourne	Lymphoedema Specialist Services Ltd	BN23 6DW

This report describes our judgement of the quality of care provided within this core service by Lymphoedema Specialist Services Ltd. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our ‘Intelligent Monitoring’ system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Lymphoedema Specialist Services Ltd and these are brought together to inform our overall judgement of Lymphoedema Specialist Services Ltd

Summary of findings

Ratings

Overall rating for the service

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Summary of findings

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Summary of findings

Overall summary

We do not currently rate independent community specialist providers.

Lymphoedema Specialist Services (LSS) are a small independent company who employed two fulltime members of staff and provided services on behalf of the NHS.

LSS are registered to provide diagnostic and screening services, treatment of disease and disorder and transport services. During this inspection, we inspected treatment of disease and disorder as this is the regulated activity the service is currently providing.

We found:

- While we found staff to be open and transparent and were able to describe incidents, LSS did not report any incidents or near misses in the last twelve months. We raised this with the registered manager (RM) who acknowledged that further training might be required to embed this through the service.
- Staff were aware of their responsibility to safeguard vulnerable adults and children. While the RM was not trained to safeguarding level three at the time of the inspection, we saw evidence that this had been achieved following the inspection, providing an appropriate level for a service that can treat children.
- Risks to patients were adequately assessed and reviewed, and we found that staff were aware of processes to follow in the event of clinical emergencies.
- Staff were actively engaged in activities to monitor and improve quality and outcomes to patients.

- Patients were involved and encouraged to be partners in their care and in making decisions, with any support they need. Staff spent time talking to patients and those close to them. They were communicated with and received information in a way that they could understand. Patients understood their care, treatment and condition. Patients and staff worked together to plan care and there was shared decision-making about care and treatment.
- Services were planned and delivered in a way that meets the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services. People's individual needs and preferences were central to the planning and delivery of tailored services. The services were flexible, and provided choice and continuity of care.
- The leadership was knowledgeable about quality issues and priorities, they understood what the challenges were and took action to address them. The service was transparent, collaborative and open with all relevant stakeholders about performance.
- LSS were aware of their risks; and had a risk register in place, however not all of the risks had a risk rating.
- The vision had been developed and staff knew of the importance of quality and compassion in the treatment of their patients.

The service proactively engaged with, involved all staff and ensured that the voices of all staff were heard and acted on.

Summary of findings

Our inspection team

Our inspection team was led by:

Team Leader: Vanessa Ward, Care Quality Commission

The team included CQC inspectors and one specialist: a registered nurse specialising in Lymphoedema care.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot community health services inspection programme.

How we carried out this inspection

To get to the heart of people who use services' experience of care, 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 visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 21 and 22 March 2017. During the visit, we spoke with a range of staff who worked within the service, such as nurses and healthcare assistants. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

Areas for improvement

Action the provider **MUST** or **SHOULD** take to improve

The provider must ensure that incidents and near misses are recorded, investigated and learning from.

The provider must ensure that staff are aware of their responsibilities in ensuring effective incident, management processes.

The provider should ensure that the translation policy follows best practice.

Lymphoedema Specialist Services Limited

Lymphoedema Specialist Services Ltd

Detailed findings from this inspection

Are services safe?

By safe, we mean that people are protected from abuse

Summary

- Staff understood their responsibilities to report safeguarding concerns. Staff held a sufficient level of safeguarding training.
- Staffing levels and skill mix were sufficient to keep people safe.
- Risks to people who used the service were assessed, monitored and managed. These included deteriorating patients and medical emergencies.

However:

- There was limited use of systems to record and report safety concerns, incidents and near misses.
- Clinical staffs uniform sleeves fell below the elbow, which was not in line with best practice.

Incident reporting, learning and improvement

An electronic system and process for reporting incidents was in place. Staff understood the mechanism of reporting incidents. The form was accessible for all staff via an electronic online system. However, we reviewed the

electronic incident reporting database and noted that no incidents had been reported between April 2016 and March 2017, despite staff giving us examples of incidents and learning from incidents. Staff gave us an example when a company did not deliver four hosiery items ordered for patients. Although staff dealt with this appropriately and informed the patients of a delay, and no harm occurred, this was not reported as an incident. This meant staff may not have fully understood the definition of an incident and the service may not have fully investigated incidents. This may have limited opportunities for the service to learn from incidents to help prevent recurrences.

Staff described the principle and application of duty of candour, Regulation 20 of the Health and Social Care Act 2008, which related to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant person) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff told patients when they were affected

Are services safe?

by an event where something unexpected or unintentional had happened. Staff gave an example of applying the duty of candour when a wrong garment was ordered and delivered to a patient.

There were no Serious Incidents Requiring Investigation (SIRI) reported by the service between April 2016 and March 2017

There were no never events reported by the service between April 2016 and March 2017. Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

Safeguarding

We saw there was an adult safeguarding protocol and a flow chart, which advised staff what action they should take in the event of safeguarding concerns. Staff told us they had not needed to make any safeguarding referrals between April 2016 and March 2017. Staff we spoke with were knowledgeable about the safeguarding protocol and processes and were clear about their responsibilities. They were able to explain their role in the recognition and prevention of abuse.

Staff had received level 1 and 2 adult and children safeguarding training as part of their mandatory training programme. The registered manager (RM) told us that LSS had provided treatment to one child under the age of 18 between April 2016 and March 2017. The national intercollegiate guidance document Safeguarding Children and Young people: roles and competences for health care staff (2014) states that, "All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns should have level 3 training." We raised this issue with the RM on the first day of the inspection, on the second day of the inspection the RM said they had reflected on this and had enrolled to undertake level 3 safeguarding training on line. Following the inspection, we received confirmation that the RM had undertaken the level 3 training, and the one child that the

provider had on their caseload would continue to be seen by the RM along side another staff member, which meant there was an adequate level of safeguarding provision to the child.

CQC received no safeguarding alerts or safeguarding concerns in relation to this service between April 2016 and March 2017.

Medicines

The centres did not stock medicines and staff did not prescribe medicines for their patients

Environment and equipment

We visited two of the three locations that LSS use to provide services. All locations were a hired room within community health centres. The health centres supplied the equipment used by LSS. LSS could access a log, which showed details of maintenance and service records of all the equipment provided. This meant there was a process, which ensured LSS knew the equipment was safe to use.

Staff knew the different weights that the treatment couches could withstand, this meant only patients within the safe weight limit could be treated on these. Each patient was weighed at the start of each appointment, which ensured the weight of each patient was known.

All equipment and hosiery were stored in well-organised storage cupboards in each community nursing base.

We saw that electrical safety checking labels were attached to electrical items. This showed they had been tested and were safe to use.

We checked over five consumable (disposable equipment) items and all were within their expiry date, which showed they were safe to use.

Cleanliness, infection control and hygiene

Cleaning of the rooms was the responsibility of the health centre where LSS hired rooms. Staff reported a

system for reporting any concerns relating to cleanliness of the rooms to the practice manager. The RM

gave us an example of when one of the locations had an issue with the cleanliness. This was raised with

the practice manager and immediate action taken to address. The clinic areas we visited in were visibly clean and tidy.

Are services safe?

We saw that the two clinical staff wore a uniform where the sleeves of the top were below the elbow, this was not in line with best practice. Staff should be bare below the elbows to prevent the risk of spreading infection. We raised this with the RM who had not realised the sleeves were just below the elbow. Later in our inspection, we noticed their sleeves had been rolled up above the elbow. Following the inspection, we were informed that LSS would be sourcing new uniform in the future and they would ensure this had sleeves that finished above the elbow. In the interim, staff would roll the sleeves above the elbow to mitigate any risk of infection.

A uniform and dress code policy was in date and seen and stated that staff should not wear any wristwatches or jewellery other than a single plain wedding band. This is in line with national infection prevention and control guidance and we observed that staff followed this policy.

During our inspection, we saw members of staff wash their hands and use alcohol hand sanitiser in accordance with the World Health Organisation (WHO) "five moments for hand hygiene". We saw hand sanitiser bottles readily available throughout clinical areas. LSS did not undertake hand hygiene audits due to the small number of staff within the service. However, we saw an action plan, which stated that following the recruitment of more staff in 2017, they would routinely begin auditing. The RM ensured compliance with the LSS infection control policy by monitoring of staff during their clinical work, and by staff completing the IPC module as part of their annual mandatory training.

We saw personal protective equipment (PPE), was used and readily available in clinic rooms. Personal protective equipment is protective clothing such as aprons, gloves, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection. We saw staff wearing gloves when appropriate.

We found equipment was visibly clean throughout the department, and staff had a good understanding of responsibilities in relation to cleaning and infection control.

Disinfection wipes were readily available for cleaning hard surfaces and equipment surfaces in between patients, and we witnessed staff using these.

Waste in all clinical areas was separated and in different coloured bags to identify the different categories of waste.

LSS did not use sharps for any of their procedures, but we saw there were sharps bins available within the clinic areas should staff come across an inappropriately disposed of sharp material.

Mandatory training

Mandatory training was provided by an external company. It was a one-day session each year, which covered 12 different modules. These included safeguarding vulnerable children levels one and two, complaints handling and conflict management, lone worker, health and safety, information governance, fire safety, infection control food hygiene, basic life support, moving and handling and protection of vulnerable adults levels one and two.

We reviewed the training records of the two members of clinical staff, which showed 100% were up-to-date with mandatory training. Of the two non-clinical staff members, one had received mandatory training in the last twelve months and the other was awaiting a date in order to complete.

Assessing and responding to patient risk

Staff received training in clinical emergencies in relation to lymphoedema for example, recognising signs and symptoms of a deep vein thrombosis and what action to take.

Staff explained to us that one of the risks associated with lymphoedema was the risk of patients developing cellulitis (a type of skin infection). We observed staff explaining the signs and symptoms of cellulitis to patients and the importance of seeking medical advice urgently. We reviewed 53 patient questionnaires, which asked if the patient was satisfied with the information given to them about their condition and the risk of cellulitis. The results showed 48 patients (92%) were very satisfied, two (3%) were satisfied and three (4%) were not sure. No patients commented that they were not satisfied. This meant almost all patients felt informed about the signs and symptoms of cellulitis.

Staff gave us examples of when they suspected patients had developed either cellulitis or deep vein thrombosis and the action they took, which ensured patients received urgent assessment by the appropriate care provider which could either be by a GP or referral to a local acute hospital.

Many patients were being actively treated for cancer. One of the risks for patients being treated with chemotherapy (medicine to treat cancer) was the development of

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neutropenic sepsis. Neutropenic sepsis is a serious blood infection, which requires immediate medical attention. We spoke to staff who were aware of this condition and described it as a clinical emergency, confirming this would require immediate transfer to an emergency department.

We saw an in date clinical emergencies in lymphoedema policy. This outlined four clinical emergencies that could occur in LSS patients: deep vein thrombosis, cellulitis, spinal cord compression and chemotherapy-induced neutropenic sepsis. The flow chart clearly documented the procedure to follow, which was to request immediate assistance from one of the GPs on site, and referral to accident and emergency.

Staff were able to calculate the amount of lymphoedema that a patient had at each appointment via the electronic recording system. This meant they were able to monitor if their condition was getting worse and take appropriate action. In addition to this, all patients were asked if they consented to photographs being taken of their lymphoedema at each appointment. This helped staff determine if a patient's condition had worsened.

Basic life support (BLS) training was part of the standard mandatory training package that all staff were required to complete. BLS training gives staff a basic understanding of how to deal with patients who have immediate medical needs, and covers techniques including cardio pulmonary resuscitation (CPR), the recovery position, how to deal with severe bleeding and shock. Mandatory training records showed 100% of clinical staff had completed this course.

Staffing levels and caseload

LSS employed four members of permanent staff, one was a registered nurse, one was an associate practitioner (AP) and there were two administration staff. A locum registered nurse undertook weekly home visits in addition to providing annual leave or sickness leave cover.

Generally, the registered nurse (who was also the registered manager) and the AP worked together. If the registered nurse was on annual leave, the clinics would be reduced so that only patients that the AP could treat were scheduled. In addition, a locum registered nurse could cover annual leave.

The AP was able to undertake some appointments on her own that she had the skills knowledge and training to do safely.

The registered manager was aware that more clinical staff were required to support the service and was planning to recruit staff in the near future.

The registered manager explained that originally LSS was contracted to treat patients who had lymphoedema associated with cancer. Local clinical commissioning groups (CCGs) then offered the contract to LSS to also treat patients with primary lymphoedema and chronic oedema, which they accepted. LSS then did not have the staff and resources to support both groups of patients so the registered manager informed the CCG and the primary lymphoedema contract was given to another provider.

LSS now predominantly treated patients with lymphoedema related to cancer. However, some patients with primary lymphoedema did not want to transfer to another provider so stayed with LSS.

Managing anticipated risks

LSS had a lone workers policy, which ensured the safety of staff. Staff were required to telephone each other via a "buddy" system when they had finished work and were going home. All clinical staff members also had personal alarms.

LSS did not have an inclement weather policy because it consisted of two clinical staff members who contacted each other at 06:30am on the day, both in the event of adverse weather, and in relation to the instruction of the clinic being provided on the day.

We saw examples of a domiciliary visit risk assessment. The documentation included assessments of four key areas: parking (accessibility, trip hazards), environment (is it clean, smoke free), violence (previous history, any pets) and manual handling (cramped conditions, non-lowering bed). While we did not review any completed domiciliary visit risk assessments, staff told us that the risk assessments were an essential part of their role when visiting patients outside of the clinic environment.

Major incident awareness and training

LSS had a combined business continuity and succession plan which consisted of a flow chart for staff to follow. As a small company, this meant in the event of the RM being incapacitated, there was a process that could be invoked to ensure the day-to-day running of the clinics could continue.

Are services safe?

Staff explained action taken during adverse weather conditions. Staff knew when the fire alarms at each location were tested and the fire evacuation procedures for each location.

Quality of Records

We reviewed three sets of patient records. These were comprehensive and well documented and included diagnosis and management plans, consent forms and evidence of multi-disciplinary input; for example correspondence to the patient's GP.

LSS had also recently implemented a secure, electronic patient record system, which was specific to the treatment of lymphoedema. Staff used this system to record the assessment and treatment of patients' lymphoedema. The system also calculated the amount of fluid retention a patient had by inputting the patients' measurements. Staff were positive about the system and said that it saved time undertaking the calculations manually.

Patient records were kept secured in a locked cabinet at two of the locations used by LSS. Notes were transported securely to the third location when required and returned to the locked cabinets. This ensured patients notes were kept securely in line with the data protection act.

We saw an audit of medical records that was completed in January 2017. It recognised that there was some missing information in some of the records. This included next of kin or emergency contact numbers, ethnic origin and follow up appointment details. An action was taken to put a note at the front of each set of notes with the missing information detailing what information was needed so this could be confirmed at the patient's next appointment. LSS planned to re-audit in June 2017.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

- Patients had effective care and treatment that met their needs.
- Patients care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice.
- Patients had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs. The expected outcomes were identified and care and treatment was regularly reviewed and updated.

Evidence based care and treatment

Staff were aware of national guidelines that supported evidence based treatment of lymphoedema. For example, staff told us that they had referred a patient for liposuction for chronic lymphoedema, which was in line with National Institute for Care Excellence (NICE) guideline IPG 251. This type of liposuction that invasively removes fluid was suitable for a limited number of patients with specific criteria, and could only be performed by specialist surgeons.

Treatment provided by LSS was in line with the British Lymphology Society (BLS) that sets out professional standards in management of lymphoedema. For example, Standards of Practice for Lymphoedema Services Guidance and a Benchmark for all Health Care Professionals and Commissioners when providing care for people with lymphoedema.

We saw that patients received manual lymphatic drainage (MLD) for treatment of their lymphoedema, which was in line with the Leduc best practice. MLD is a type of massage that drains fluid and reduces lymphoedema. Staff were also trained in the Casley Smith technique. This was a systemic approach comprising of hand manoeuvres, strokes and breathing exercises to help with the drainage of the affected area.

We saw patients received elastic taping for the treatment of their lymphoedema. Elastic taping gently lifts the skin, which allows the lymphatic vessels underneath to absorb and drain lymphatic fluid and reduce the amount of lymphoedema.

Patients who required compression garments were given two sets, and the provider had a process in place for the forward planning and ordering of these garments, which was in line with 2004 NICE guidance CSG4 "Improving supportive and palliative care for adults with cancer".

End of life care (EOLC) patients had additional documentation within their records. We saw an example of this, which included details of the named palliative care nurse, the disease status, and the Karnofsky performance status rating. This was a tool used to help classify what level of normal function an EOLC patient was able to carry out, for example 100% would represent a patient who had no issues impacting on their normal life, whereas a 50% score would demonstrate the patient needs considerable assistance and frequent medical care.

Nutrition and hydration

LSS did not use a malnutrition universal screening tool (MUST) to help identify patients who were malnourished or at risk of malnutrition, however staff told us they gave patients advice on the importance of eating a nutritionally balanced diet and supported patients who wanted to lose weight and we saw patient information leaflets with this in.

Staff explained that they could refer patient to speech and language therapists or dieticians via the patient's GP if needed.

We saw a patient information leaflet regarding multi-layer bandaging. This advised patients of possible side effects, including increased frequency of urination. The leaflet advised that this was normal and should not affect patients' abilities to get on with normal activities, although it advised patients to stay well hydrated while undergoing this treatment.

Technology and telemedicine

LSS did not provide telemedicine services.

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Patient outcomes

LSS participated in Commissioning for Quality and Innovation (CQUINs). This was a payments framework that encouraged providers to share and continually improve how care was delivered and to achieve transparency and overall improvement in healthcare. For the patient, this meant better experience, involvement and outcomes. The CQUINs that LSS completed were related to response times (referral to treatment) to ensure geographical equity between the three sites, and the target compliance rate was 90%. Between April 2016 and March 2017 LSS achieved a compliance rate of 100%, which was better than the 90% target.

One of LSS' key performance indicators provided by the clinical commissioning group (CCG) was to evidence a reduction in cellulitis episodes (infection of the skin, which can be caused by fluid build-up in lymphoedema patients). LSS reported a 93% of patients had reduced episodes of cellulitis, which was better than the CCG target of 90%.

The aim of treatment with all lymphoedema patients was to reduce the oedema or swelling. LSS audited ten patients seen between April 2016 and March 2017 and we saw that 50% of patients had an 11% - 69% reduction in the swelling of their lymphoedema. The other 50% of patients did not see an improvement, due to either active disease, or the disease affecting both limbs. The auditing of these outcomes meant the provider monitored the effectiveness and outcome of treatment.

LSS audited the timeliness of the provision of compression hosiery to patients. Compared to an audit completed in 2014, we saw that there was a significant improvement in the time taken to provide patients with their hosiery in 2016. For example, in 2014 the audit showed that 20% of patients waited more than 21 days to receive their hosiery, compared to 2016 where no patients waited more than 21 days, with the majority (54%) waiting less than seven days.

One patient told us that because of a course of multi-layered bandaging they had received, it had changed the shape of their leg and they were now able to wear trousers.

All patients we spoke with reported a decrease in the amount of lymphoedema they had which had a positive impact on their lifestyle.

Competent staff

Staff had the skills and knowledge required to undertake their roles. We reviewed the training log completed by the

associate practitioner (AP) which showed completion of training in lymphoedema care. There was evidence staff were assessed on competencies before being allowed to deliver care. For example, five competencies were undertaken which included theory and practical assessments relating to lymphoedema care and the technique of measuring oedematous arms and legs for routine and palliative patients.

We saw the AP had a current job description, which set out the roles and responsibilities of their role. The AP told us that they always practiced within their limitations of their training and experience. The AP told us that support and advice was always available if they required it from the registered manager.

Staff told us there were training opportunities available and they were supported to develop. They gave us examples of education and training they had recently completed.

The registered nurse had undertaken extensive national qualifications in relation to lymphoedema.

Staff were recruited via an external human resources company. They were responsible for ensuring references, photographic identification, copies of certificates, Nursing and Midwifery (NMC) registration validation and disclosure and barring service (DBS) checks were undertaken. We saw that the RM had a current DBS certificate.

We reviewed a completed induction checklist, which included milestones to be met for example, on completion of the first day, first week and first three months. This ensured staff had an adequate induction to LSS and were familiar with policies and procedures. We spoke with a new member of staff who described the induction they had received as supportive.

We saw an example of a completed appraisal. This included objectives, reflection, training and an overall performance score on a scale of 0-10 (with 10 being excellent), as well as a vision for the coming year.

Multi-disciplinary working and coordinated care pathways

The provider worked closely with other agencies, for example, hospices and district nursing teams. The provider undertook dual assessments with palliative care or district

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nurses and worked together cohesively. We saw a plaudit received from a palliative care consultant from one of the local hospices, which described LSS' "commitment to professionalism and patient care" as "inspiring".

The provider could refer to other agencies or organisations if required, for example, dieticians and tissue viability teams.

Staff gave us examples of times they had contacted patients' GPs if they had required advice regarding a patient. The provider sent emails and letters to the patients GP with contained details of the care and treatments given, this ensured they were kept informed and could provide continuity of care.

The provider could obtain advice from other agencies if required for example they could discuss a patient with a specialist cardiac nurse if required.

All of the clinic sites were based in GP surgeries. We observed good working relationships between the GP surgery staff such as the receptionists and practice managers and LSS staff working together. Staff felt able to speak with GP practice staff if there were any issues relating to the room they were using or if any concerns arose.

Referral, transfer, discharge and transition

Between April 2016 March 2017, 262 referrals were received by LSS. Of these, most (77 patients, or 29%) were referred by the patient's GP. The breast cancer care teams based at local acute hospitals accounted for 72 referrals (27%), the palliative care community team referred 15% of patients (38) and the two local hospices referred 30 patients, accounting for 11% of all referrals. The remaining 28% of referrals came from other teams including district nursing and oncology teams.

Each patient underwent an hour-long assessment at the first appointment. This allowed time for all the relevant information to be obtained. The GP referral letter contained details of past medical history, reason for referral and medicines the patient was taking.

We saw most of the referral letters were comprehensive and contained all the relevant information including any allergies the patient had. However, in one set of notes, the allergy status and current treatment sections were left blank. Each referral was triaged by the registered nurse who then decided how urgently the patient needed to be seen and whether further information was needed from the

referrer. The patient was then written to with the date, time and location of their appointment. Due to the nature of lymphoedema, which was a lifelong condition, most patients were not discharged from the service.

We saw correspondence between the CCG and the provider regarding non-compliance- of a patient with their treatment. The provider subsequently discharged the patient from the service. We saw a full letter of explanation was sent to the patient's GP, discharging the patient back to the GP's care.

Access to information

The provider had a secure electronic database, which contained different folders of information, for example, risk and incidents, staff education, mental capacity, duty of candour and staff meetings. All the information was in one place and we saw staff accessing it easily. This meant staff had easy access to documents containing support and guidance.

When patients were seen in clinic, their notes would always be accessible through the electronic system and paper files. Staff told us that one of their challenges when seeing patients in the community setting (for example, in the patients home) that they could not access the community electronic patient notes system.

Staff travelled between different clinics with encrypted laptops and mobile telephones. Staff were encouraged to remain "paper light", which minimised the risk of paper work being misplaced.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

Staff explained verbal consent was taken from the patient at the beginning of each appointment and written consent was taken at the end of each appointment. This was not usual practice where written consent would be obtained at documented before any treatment commenced. Staff explained they felt it was not appropriate to obtain written consent at the beginning of the appointment as the plan of care had not been decided and the patient would not be informed of what they were signing for. They had not had any issues with this process in the last twelve months and as patients would offer verbal and implicit consent before commencing treatment, this was appropriate.

Patient records we reviewed showed the appropriate consent had been obtained and correct records were kept

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in-line with best practice. Consent forms for medical photography were also correctly completed. We observed that staff took time to explain to patients why they were signing the consent form.

Staff understood their requirements of relevant legislation and guidance including the Mental Health Act 2005. Staff also demonstrated good knowledge of the Deprivation of Liberty Safeguards (DoLS). We saw staff were up to date with mental capacity act training.

We witnessed staff members gaining verbal consent from patients before and during treatments and ensuring the patient understood the care they were receiving.

Administrative staff used a mental capacity tool when speaking to the patients on the telephone to confirm or book appointments.

All staff received dementia training as part of their mandatory training course.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

- Feedback from patients continually positive
- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity.
- Patients could access national support groups that LSS signposted them to.
- Staff considered patients emotional wellbeing alongside their physical condition.

However,

- We saw that on one occasion a member of administrative staff worked within the clinic room during a consultation. This may have compromised the patient's privacy.

Compassionate care

We spoke with six patients who used services provided by LSS. All patients we spoke with felt staff were caring and compassionate. One patient told us "I have learnt something more about my problem and [LSS] have made me hopeful". We observed staff and their interactions with patients were professional, friendly and kind.

We saw staff took time talking to patients and explained things to patients and those close to them. An example of this was a letter received from a healthcare professional working in a local hospice, who wrote to praise a staff member who "gave extra time on a Saturday to see a patient who was not on the list. The kindness and empathy showed to the patient was engaging to watch".

Staff treated patients with privacy, respect and dignity and this was seen when they protected patients from cold and exposure, using blankets to maintain dignity. In the clinics, staff drew the curtains and closed the doors to ensure privacy. Staff knocked on doors before entering. However, during one consultation, we noted that an administrative member of staff worked at their computer in the clinic room. While the patient was given privacy by a closed curtain, the member of staff could overhear the consultation, which did not fully promote privacy and dignity. The RM acknowledged this was not an ideal situation, but informed us that they were limited financially

and could not realistically rent additional rooms at each clinic site. However, LSS informed us that upon collection from the waiting room, patient's would be informed of the presence of an administrative member of staff, and permission was sought for them to be there. LSS told us that as yet they have not had a patient decline this.

Staff adapted their assessments and treatments to meet the individual needs of each patient. For example, providing treatment in different positions, which ensured patients were comfortable.

All of the patients we spoke with were complimentary regarding the care and efficiency of the staff. Comments such as "not to be too dramatic but they have given me my life back" and "previously I could hardly mobilise before treatment; now I have my independence back".

All of the staff we spoke with took great pride in their work and were committed to providing the best care they could.

We reviewed 81 completed patient questionnaires of these 59 patients said they were very satisfied with the treatment they had received, 20 were satisfied, one patient did not answer and one patient was not satisfied. The RM spoke to the patient who was unsatisfied as they could not access lymphatic massage. This was discussed and resolved with the patient and the RM added this to the feedback register. All patients said staff treated them with dignity and respect. Comments from the completed patient questionnaires included "staff had good interaction and had the ability to make the patient feel heard" and "I cannot sing their praises enough".

Understanding and involvement of patients and those close to them

Staff demonstrated an understanding of the importance of treating patients and those who were important to them in a caring and sensitive manner.

We saw that staff did not use jargon when speaking to patients to ensure they understood what was happening and explained the process before carrying out procedures. Staff took time to explain what they were going to do and phrased this to a way each patient would understand.

Each patient had a plan of care, which was discussed with the patient at the end of their appointment. These

Are services caring?

included goals and advice for patients for example, to exercise and moisturise skin regularly. Patients were given a copy of their plan of care, which they could refer back to if required.

We spoke with staff who told us how valuable the service was and how motivating it was seeing patients walk out better than they walked in.

Emotional support

LSS did not run a support group for patients, although this was an aspiration of the provider to hold in the future. Staff knew how to access different support groups and organisations for patients if required, for example the

Alzheimer's society, Parkinson's society, and Age UK. Staff also provided details of the national Lymphoedema Support Network (LSN), a charity, which provides information and support to lymphedema patients.

One patient commented, "The two ladies treating me have done more than just help me with my lymphoedema". They were more than considerate of my ailment and looked after me with great care and I thank them from the bottom of my heart for helping me through this".

We observed that staff did not just treat patients with their physical symptoms of lymphoedema they considered their emotional needs and provided support and advice. Staff could refer patients to a counselling service if required.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

We found:

- Services were tailored to meet the needs of individual patients and delivered in a way to ensure flexibility, choice and continuity of care.
- People could access the right care at the right time. Access to care was managed to take account of patients' needs, including those with urgent needs.
- The facilities and premises were appropriate for the service being delivered.

However:

- The translation policy in place at the time of our inspection did not follow best practice.

Planning and delivering services which meet people's needs

Most patients referred to LSS (143 patients, or 53%) suffered from secondary lymphoedema. End of life care (EOLC) patients made up 29% of referrals (78) and non-cancer referrals made up 41 referrals (15%).

There were three main treatment pathways and timescales for patients to be seen within set by the clinical commissioning groups (CCGs). Routine or elective patients were required to be seen within six to eight weeks, urgent patients within three to four weeks, and EOLC patients within five working days. During 2016, LSS managed to see 100% of patients for their first appointment within these timeframes.

Clinics ran from 8.30am to 4.30pm Monday to Friday, except on Wednesday where clinic started at 1.30pm. If patients required treatment outside of these clinic times, the RM would try to accommodate these requests where possible. An example of this was when an EOLC patient was seen by the RM on a Saturday within the hospice setting, demonstrating the service's ability to remain flexible and responsive to patient needs.

LSS provided services at three different locations and patients could choose with location they preferred to attend for treatment. Treatment could also be provided in alternative locations if required. For example, patients could receive treatment in their home or in hospices. There

was one location which had a bariatric (high body mass index) treatment table, which meant bariatric patients could receive treatment. Staff described an incident where a patient attended a clinic where there was not a bariatric couch available, so they attended the Hastings clinic with the agreement of the patient.

Parking was available at the clinics we visited. In the Eastbourne clinic, this was free for patients, in the Hastings clinic, local council parking was available at a fee.

We saw LSS used a database for the ordering of garments and hosiery for patients. A member of the administration staff was responsible for the ordering of the garments and invoicing the appropriate CCG's for reimbursement. The garments were then delivered straight to the patients home. Staff told us that this was a long-term pilot scheme with the CCG's as previously all garment and hosiery orders were done via the patients GP. Staff and patients were positive regarding this system and felt it was a more reliable service for patients. Patients described previous delays and wrong orders when items were ordered via their GP.

LSS used one company mainly for garments and hosiery. The registered manager explained this was because the company delivered the items to the patient's home for no extra charge. If required they could order items from other companies and made-to-measure items.

LSS routinely allowed one hour per appointment, however staff were able to schedule appropriate time for each patient dependent on their needs, and understood when more time was needed adjustments could be made to ensure appropriate care was given. For example, more time could be allocated to more complex patients, which allowed for any unexpected circumstances.

Staff told us that some of their patients had hearing difficulties and communicated with them via text messaging if required. Text messaging was also used as an appointment reminder for patients who opted into to receive these. If patients preferred, they would receive a telephone call from one of the members of the administrative team reminding them of their appointment date and time approximately one week prior to their appointment.

Are services responsive to people's needs?

We saw that LSS had produced patient information leaflets specially designed for patients with learning difficulties. These included more pictures and larger, jargon-free text to help patients understand their treatment.

Equality and diversity

Staff we spoke with were aware of the need to obtain interpreting services when required and could describe the process for doing so. This meant that staff could communicate effectively with all patients where English was not their first language. However, the LSS language and interpretation policy stated that in the first instance a friend or family member would be used to translate if possible. It is not considered best practice to use family members for translation. Interpreters should be impartial and have appropriate training so staff have assurances they communicate important medical information correctly and do not try to influence the patient's decisions. We discussed this with the registered manager who told us that although translation services were available if required via a third party, it had a cost implication. This was an issue that the RM planned to discuss with the CCG.

Staff told us they could access information leaflets in other languages if needed and the local NHS trust could help facilitate this.

Meeting the needs of people in vulnerable circumstances

Staff were able to give us examples of caring for people living with a learning disability and the adjustments made, for example, taking time to talk to patients, using simpler language and diagrams to explain treatment when appropriate.

All clinic locations were wheelchair accessible.

The provider had different patient information leaflets for patients living with a learning disability that used simple language and picture and diagrams to explain care and treatment.

Staff told us that they rarely treated patients living with dementia, but they had received dementia awareness training and were able to give examples of adjustments they would make.

Access to the right care at the right time

There were national targets for response times for urgent patients (21 days), routine patients (70 days) and EOLC (7 days) referral to treatment. LSS had agreed shorter

response times Commissioning for Quality and Innovation (CQUIN) with the referring CCGs, agreeing to see urgent patients within 10 days, routine patients within 56 days and EOLC patients within five days. LSS were expected to see 95% of patients within these targets, and we saw that 100% of patients were seen within these timeframes.

Furthermore, The average timeframe for which patients were seen was 3.67 days for EOLC patients, 10 working days for urgent patients, and 35 days for routine / elective patients, which was better than the target response time.

When appointments were cancelled, patients were telephoned as soon as possible and told of the delay, and offered the next available appointment. We saw there was a late cancellation and did not attend (DNA) policy in place. However, this policy was overdue for review. Where a patient missed an appointment, the policy stated that if there was no contact from a patient within seven days of the referral, they would be discharged back to the referring GP. However, in practice, staff contacted patients that DNA to not only check on their wellbeing, but to see if they still needed another appointment. This meant that patients who did not knowingly DNA could still book another appointment instead of being discharged and then re-referred. Since the inspection, we saw that LSS had developed and updated this policy.

We saw when a new patient was advised they needed to wear a hosiery item for their treatment they were made an appointment for the following week. This ensured the garment fitted correctly.

Learning from complaints and concerns

We saw the LSS Feedback and Complaints Policy, which was within its review date. The responsible person for dealing with complaints and feedback had access to advice from an external human resources company for any issues which may have affected staff. The provider's policy was to acknowledge all complaints within three working days, and provide a written response within 20 working days.

Between April 2016 and March 2017, there was only one formal complaint to LSS. This was investigated and the patient was subsequently discharged. The complaint was responded to within the policy time frame of 20 days. Staff told us they would always try to address complaints informally in the first instance to avoid escalation into a full formal complaint.

Are services responsive to people's needs?

Staff actively listened and learnt following complaints and concerns raised by patients. For example, staff gave us an example that one patient complained verbally that the clinic was difficult to find. The provider subsequently

included a map in their appointment letter of the clinic location, which we saw. This showed that the provider had listened to concerns and made changes to improve patients' experiences.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

- The leadership actively shaped the culture through effective engagement with staff, patients, their representatives, and stakeholders. All staff we spoke to talked of a positive culture and how happy they were in their roles.
- The provider monitored quality through the completion of locally set CQUINS and key performance indicators (KPIs)
- The provider encouraged patients to participate in patient satisfaction questionnaires, and had an informative website that provided information about the service.
- LSS had a risk register in place and were aware of the risks to the service. However not all of the risks had a risk rating. This meant the provider might not be fully aware of the impact of all risks on the risk register.

Service vision and strategy

There was a draft strategy and business plan in place. This prioritised the recruitment of further associate practitioners (AP) to enable more flexible working across the three sites. Staff we spoke with were aware of the strategy of recruiting further staff. This showed staff were engaged with the service's strategy.

The LSS vision was to "become the leading organisation in the South East, providing high quality specialist care and provision that provides excellent outcomes for patients". Staff we met spoke passionately about providing quality care to patients.

Governance, risk management and quality measurement

We saw an LSS service risk register. This listed 16 risks, two of which were rated as high' and the other 14 risks were not rated. The document had sections to define the hazard, controls and risk rating. The highest rated risk was the potential for loss of information through travelling between clinic sites. There were control measures listed, including compliance with information governance training and use of encrypted devices such as laptops and mobile

telephones. The second highest rated risk was the limited access to NHS patient records, which could result in LSS staff not being aware of underlying medical conditions. This could affect or contraindicate lymphoedema treatment.

There were no incidents or near misses reported by LSS, even though staff described an incident regarding delayed hosiery, and learning from an incident where a patient had difficulty finding the clinic, verbally to us. This may mean that the provider was obtaining false assurance around incidents occurring at the service. Following the inspection, the RM advised us of an action plan to address this. This included a training session to help re-define incidents and near misses to enable better understanding of what and when to report, and an update to the incident reporting policy to reflect this. LSS also planned to introduce an "incidents officer" to oversee and monitor the reporting.

By monitoring key performance indicators (KPIs) for cellulitis, Commissioning for Quality and Innovation (CQUINS) for referral to treatment time and results of patient questionnaires, LSS were able to monitor the quality of the service provided to their patients.

Leadership of this service

The registered manager (RM) who was also the director, lead clinician and registered nurse, led the service and line managed the associate practitioner (AP) and the locum lymphoedema nurse. The AP provided support to the RM and was also the service manager. The AP provided line management to the two administration staff.

The RM was knowledgeable about service users and staff needs. They were a dedicated, experienced leader and committed to their roles and responsibilities. This was demonstrated by the RM never turning off her work telephone, and working at weekends where it benefitted the patient. We saw strong leadership with staff praising their manager regarding their support, passion and communication.

Staff gave us examples of when their managers had provided extra support, for example allowing them to work from home.

Are services well-led?

Staff described their managers as fair and flexible. Staff said their managers were willing to listen to concerns and tried to resolve issues. Staff felt valued, cared and empowered by their managers.

Culture within this service

Staff encouraged candour, openness and honesty. Staff said they were encouraged to raise concerns. All staff felt comfortable about raising any concerns with their manager and staff told us they were not frightened or worried to talk to their manager if something had not gone as planned. However, staff were also aware of external human resources procedures should they ever feel unable to discuss an issue with their manager.

All staff told us they enjoyed their jobs and felt valued. They told us that there was an open communication and good working relationships.

One member of staff told us “I love working here, love the variety of the role in helping people. It’s brilliant.” We spoke with to a member of staff who had been employed by LSS in an administrative role. After seeing the positive impact the service made on patients’ lives, they were now in the process of developing into the role of associate practitioner with the provider’s support..

Staff were committed to making improvements for patients and felt they had been given the right tools to achieve this. Staff told us they felt empowered to make changes.

Public engagement

Patient satisfaction questionnaires were available in clinics patients were encouraged to complete these. This provided the opportunity for patients to give feedback on any areas they felt needed improvement.

LSS’ website provided information about the services provided. This meant the local population could use this to make decisions about where they received their care.

We saw a poster featuring a LSS patient that had been used at national conferences. This included photographs of the patient’s affected limb before and after treatment, which demonstrated a significant improvement in the reduction of swelling. We saw the featured patient in the clinic who asked for a copy of the poster for their own records.

Staff engagement

Staff were able to work flexibly in order to support their work life balance. For example, if staff worked extra hours they could take these hours back or be paid for overtime.

Funding was available if staff highlighted training needs or if they wanted to develop their skills and knowledge.

Staff told us there were monthly team meetings, and we saw minutes from these. Staff told us that outside of these meetings, they had regular contact with the RM who kept them informed of any changes or news.

Innovation, improvement and sustainability

Innovation was encouraged and staff kept up to date with the latest treatments available for lymphoedema.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance
Transport services, triage and medical advice provided remotely	17. — (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.
Treatment of disease, disorder or injury	(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; (f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (b).
	How this regulation was not met: Incidents were not formally documented and some risks on the risk register did not have a risk rating.

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.