Healogics Limited

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Community health services for adults	Healogics Wound Healing Centre – Burgess Hill	1-1493766842
Community health services for adults	Healogics Wound Healing Centre – Eastbourne	1-1493766688
Community health services for adults	Healogics Wound Healing Centre – East Grinstead	1-2250793122
Community health services for adults	Healogics Wound Healing Centre – Haywards Heath	1-1493766751
Community health services for adults	Healogics Wound Healing Centre – Ifield, Crawley	1-1493766720
Community health services for adults	Healogics Wound Healing Centre - Horsham	1-1493766811

This report describes our judgement of the quality of care at this provider. It 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.

Summary of findings

Contents

Summary of findings

Overall summary

We found the following areas of good practice:

- Staff treated patients with kindness and compassion at all times. We saw staff involved patients in decision making about their care.
- There was evidence of multidisciplinary working within the organisation and with external agencies such as local community health providers.
- There was evidence of incident reporting and dissemination of lessons learned.
- Staff had the appropriate skills and knowledge for their roles.
- The organisation actively supported staff to develop and extend their knowledge and competencies, and encouraged innovation.
- Staff were supported with strong local leadership. Staff felt valued and had a clear understanding of the organisations vision and strategy.
- The provider was flexible and delivered care to meet the patients' needs.
- Complaints were treated fairly and with compassion and taken seriously.

However:

- The provider did not meet its mandatory training rate targets for several training modules including safeguarding and infection control.
- Patient records were not always complete, and staff did not always record patient information or their rationale for treatment decisions.
- The Eastbourne clinic raised concerns about patient access and privacy. The provider was aware of the Eastbourne clinics limitations. At the time of inspection they had identified a site for a new clinic and they report they moved locations in May 2017. Therefore information specific to the Eastbourne site may not be applicable. However, we are required to report on what we saw on the day of inspection and unable to report on a site we have not seen.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Summary of findings

The five questions we ask about the services and what we found

We always ask the following five questions of services.

Are services safe?

Summary

- There was a positive, no blame culture towards incident reporting and we saw evidence of learning from incidents. Staff understood their responsibilities under the duty of candour regulation.
- The environment and equipment at all of the sites was visibly clean and well maintained.
- There were systems, processes and standard operating procedures that were reliable and kept patients safe.
- Staffing levels were planned according to the amount of patients requiring care and treatment and we saw sufficient levels of staffing throughout our inspection.
- We saw the provider had systems in place to assess and respond to anticipated risks.

However:

- Mandatory training compliance, including Safeguarding and Infection Prevention and Control, was worse than the providers 100% target. Hand hygiene audits were worse than the provider's target.
- Moving and handling risk assessments had not been completed for some high risk staff activities.

Are services effective?

Summary

- Services were delivered in-line with current national guidelines and were monitored to ensure compliance.
- Patients had comprehensive assessments of their needs and were included in decision making and wellbeing.
- We saw evidence of effective multidisciplinary working; teams worked collaboratively to understand and meet the range and complexity of people's needs.
- Appropriate awareness and training in the Mental Capacity Act and consent was seen and staff understood their roles in relation to this.

However:

- Not all staff had a current appraisal due to a recent change in appraisal methodology.

Summary of findings

- Staff did not always update patient records to reflect the reason for clinical decisions.

Are services caring?

Summary

- Feedback from patients and their relatives was continually positive. We witnessed staff gave patients the time to listen to their concerns and offered support where needed.
- Staff explained and ensured that patients and carers had a good understanding of procedures before undertaking them.
- Staff showed kindness and compassion, they respected patients dignity at all times and were sensitive to patients' needs.

However:

- Privacy and dignity could not be maintained in the bay area of the Eastbourne clinic.

Are services responsive to people's needs?

Summary

- The provider was flexible and delivered care to meet the patients needs.
- There was continuity in patient care. Patients generally saw the same staff members who knew them and their care needs.
- The needs of patients were considered and used to make changes to the service. Urgent needs were catered for and waiting times and delays were minimal.
- Staff were able to schedule appropriate time for each patient dependent on their needs, and understood that when more time was needed adjustments could be made to ensure appropriate care was given.
- Complaints were treated fairly and with compassion and taken seriously.

However,

- Patients without carers may not have the same access to care as patients with carers if they cannot transfer from a wheelchair to treatment couch independently.
- Patient complaints, comments and feedback were not defined and staff demonstrated lack of clarity about how to classify patient comments. This could result in patients' concerns not being classified and responded to appropriately

Summary of findings

Are services well-led?

Summary

- There was a clear governance structure with communication to the executive team. Staff felt supported by their line managers and felt confident to raise concerns with them. There was a strong visible local leadership who together with the staff were committed to improving patient care.
- We saw staff and managers shared the same vision and strategy and staff survey results reflected this.
- Risks were regularly reviewed by the senior team and staff were able to describe the risks to the organisation.

Summary of findings

Our inspection team

Our inspection team was led by:

Team Leader: Vanessa Ward, Care Quality Commission

The team included two CQC inspectors and two specialists who were registered nurses specialising in wound 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 20 and 21 February 2017. During the visit, we spoke with a range of staff who worked within the service, these included nurses, healthcare assistants, administration staff, managers, and senior management. We observed how people were being cared for and reviewed care or treatment records of people who use services. We met with people who use services, who shared their views and experiences of the core service.

Information about the provider

Information about the service

Healogics Limited is the registered provider for Healogics Wound Healing Centres based across nine sites in the United Kingdom. This report covers seven of these sites based in the south east of England. The main types of care provided are wound care and treatment of lymphoedema. The type of service each site provides is dependent on the agreed contract with the local clinical commissioning groups (CCG). The service is currently contracted to treat adults.

The provider also offered their services to self-paying patients. Self-paying patients could get the same care provided to NHS patients as well as some other services such as manual lymphatic drainage which is a technique used to massage patients with lymphoedema.

The main site and headquarters for the service is based in Eastbourne where the service is commissioned by the local CCGs for both lymphoedema and wound care. There is also a site based at a health centre in Hastings contracted to provide the same service by a different CCG. The other five sites are within the Crawley, Horsham and Mid-Sussex (CHMS) and Eastbourne, Hailsham and Seaford (EHS) areas, commissioned by two CCGs.

In 2016 there were 660 referrals from the EHS CCG, 698 from the CHMS sites, and 149 from the Hastings & Rother and High Weald Lewes and Havens CCGs.

We visited six out of the seven sites and spoke to 13 members of staff including tissue viability nurses, nurse consultants, healthcare assistants, managers and administration staff. We spoke to nine patients and reviewed 56 patient feedback comment cards. We

Summary of findings

observed the delivery of care in clinics, and in the community on a domiciliary visit (a visit to the patient's home to provide care). We reviewed 16 sets of patient notes.

Good practice

The recently published paper in the Journal of Community Nursing about promoting patient concordance to support rapid leg ulcer healing reflected that the staff are innovative and driven to provide meaningful care to patients.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- Ensure all staff have completed appropriate levels of safeguarding training.
- Ensure that all staff are completing their mandatory training.
- Ensure the flooring at the Eastbourne clinic is in line with the Department of Health's Health Building Note (HBN) 00-09 and are using furniture that they are able to wipe clean in their clinic spaces.
- Ensure moving and handling risk assessments are undertaken for staff moving heavy items such as buckets of water.
- Ensure that they are meeting national referral target times.
- Ensure that they have defined 'complaints', 'concerns' and 'feedback' and that they are responding to patients' comments in line with their policy.
- Ensure that they are communicating with staff at all levels.
- Ensure that they are engaging with staff throughout the process of changes.

Healogics Limited

Detailed findings

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

Summary

- There was a positive, no blame culture towards incident reporting and we saw evidence of learning from incidents. Staff understood their responsibilities under the duty of candour regulation.
- The environment and equipment at all of the sites was visibly clean and well maintained.
- There were systems, processes and standard operating procedures that were reliable and kept patients safe.
- Staffing levels were planned according to the amount of patients requiring care and treatment and we saw sufficient levels of staffing throughout our inspection.
- We saw the provider had systems in place to assess and respond to anticipated risks.

However:

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Our findings

Incident reporting, learning and improvement

Incidents were reported by accessing a form stored on the provider's intranet. A total of 49 incidents were reported in 2016 across all seven sites, of these 10 were categorised as clinical incidents and 39 non-clinical. A total of 19 incidents were reported between January 2017 and February 2017, the majority of which were either related to information technology issues such as temporary loss of the shared network. Clinical incidents reported were varied, including sharps injuries to staff and a patient who became unwell and required transfer to the local acute hospital. Staff we spoke with understood their responsibility to report incidents and near misses and could verbally explain the process to us.

We saw examples of change following learning from incidents. For example, following a spillage on a patient's clothes requiring staff members to go out and buy a replacement to ensure their dignity was maintained, they now keep a number of spare items of clothing at the base for patients to utilise if required.

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The provider was aware of their responsibility to report serious incidents in line with the Serious Incident Framework 2015 and there were none reported by the service. The provider reported no never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

The provider was not required to report Harm Free Care data to the CCGs. Harm free care is defined by the absence of pressure ulcers, harms from falls, urine infection in certain patients and venous thromboembolism (VTE). The provider had seen eight patients with pressure ulcers or VTE which they reported to patients' GPs.

Staff described the principle and application of duty of candour, Regulation 20 of the Health and Social Care Act 2014, 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 us that they had recently undertaken duty of candour training but we did not see this included on the training records we reviewed. However, staff were able to give us examples of incidents that would trigger the duty of candour response.

Safeguarding

All members of staff completed level one safeguarding adults and children training as part of the induction programme and subsequent annual training sessions. In addition to this, all clinical staff members were required to complete level two safeguarding adults and children training.

Staff we spoke with were able to describe how they would identify and respond to safeguarding concerns. We observed safeguarding flowcharts in staff offices that staff could refer to if they were unsure.

All administrative staff had completed their level one safeguarding adults and children training. However, only 39% of clinical staff members had completed their level 2 safeguarding adults training and 70% had completed safeguarding children training. This was worse than the mandatory training target of 100%.

We spoke with managers regarding the poor compliance. They explained that there had been a recent change to the training program and staff who had previously been required to update their training every three years, were now required to update it yearly. This meant that staff who would have previously been up to date, but had not completed their training in the last year, were out of date following the change. We saw that training dates were booked for staff members affected; this meant the provider had a plan which ensured staff would be compliant.

No staff members at Healogics were level three children safeguarding trained which was acceptable because they were currently only contracted to treat adults and had not treated any children in the last twelve months.

The CQC received no safeguarding alerts or safeguarding concerns in relation to any of the seven Healogics Wound Healing Centres in the last 12 months, as of 12 December 2016.

Medicines

The centres did not stock or prescribe medicines. Staff would refer patients that required medicines to their GP.

Environment and equipment

We saw manual handling risk assessments (to look at the risks to staff when they were lifting and moving) were undertaken for staff. We spoke to staff who advised that one of the biggest issues they faced was moving of the buckets filled with water to clean patients' legs.

Space in some of the clinic areas was limited which meant staff had to pull and manoeuvre heavy buckets

in difficult spaces. We were advised that risk assessments for manual handling were completed and we

saw these. However, we did not see risk assessments related to the moving of heavy buckets of water, although the issue was on the provider's risk register, indicating that the risk may not have been properly assessed and risks mitigated to avoid injury to staff.

We saw that the provider monitored the maintenance of their medical equipment via an electronic database. We saw that two items; a plinth and a podiatry (foot examination) bed) were overdue annual servicing but we saw that these were booked for servicing for the following day.

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Supplies were stored in lockable cupboards at the various clinics. We checked over 40 consumable (disposable equipment) items and all were within their expiry date, which showed they were safe to use.

We saw electrical safety testing stickers on equipment, and staff told us that this was managed yearly by an external company who came to test all relevant electrical equipment and the equipment we saw was in date.

At the Eastbourne clinic, there was a small store area labelled 'staff only'. This door was wedged open and we saw there were dishwasher tablets at a low level. Whilst the risk of small children or patients accessing this area was low, this could still pose a safety risk due to the toxicity levels of dishwasher tablets.

Quality of records

We reviewed 16 sets of patient records. We found the majority to be well organised, complete, legible and up to date. However, we saw notes where documents including the nine essential steps to wound care were not completed in one case. Other omissions included three records where background information was not competed and pain was not recorded, one where wound information was omitted and two where information supporting treatment decisions was not recorded in the notes.

Patient records audits were completed in 2016. These audits measured compliance against different aspects of a patient's pathway such as the initial assessment, nine steps to essential wound care documentation and standard record documentation for example, dates, and signed consent forms. The organisation overall records audit score was 84%, this was slightly worse than the organisation's 85% target. The Eastbourne site performed worse than the target at 71% and the Crawley, Horsham and Mid-Sussex (CHMS) sites achieved 96%, which was better than the target. This meant that records were not always updated with relevant background and care information.

We saw that the management team were addressing this by using a red, amber, green (RAG) rated action plan, to ensure compliance improved.

In order to measure progress of healing wounds, staff took photographs of the wound at each appointment. We observed staff taking photos, then uploading these to the secure electronic system and deleting them m the camera, minimising the risk of photos being lost or inappropriately accessed. We saw that information governance training was part of the organisations mandatory training, 96% of staff had completed this training, which was worse than the 100% target for mandatory training.

Whilst in clinic, the patient records were stored in lockable filing cabinets that only Healogics staff had access to, ensuring security of the records. At the end of a clinic, staff would transfer the notes into lockable trolleys or cases in order to transport them back to one of the main sites (Eastbourne or Horsham) where they could then be transferred for archiving.

Cleanliness, infection control and hygiene

All clinical members of staff we saw were bare below the elbow. This was in line with national guidance to prevent the spread of infection. Infection prevention and control training was part of mandatory training, and we saw that 91% (10 out of 11 staff) had completed this training for the Eastbourne site and 83% (10 out of 12 staff) for the CHWS sites. This was worse than the target compliance for mandatory training which was set at 100%.

We saw that the hand hygiene audit for October 2016 scored 78%, which was worse than the 90% target. Senior staff explained that after this audit they reminded staff about the World Health Organisation (WHO) five moments for hand washing and posted hand washing posters by all sinks to remind staff how to wash their hands effectively. We saw that staff washed hands before and after providing care in accordance with the WHO five moments of hand hygiene.

The clinic areas we visited were visibly clean and tidy and corridors were free from clutter.

The clinical floor of the Eastbourne clinic was laminated but did not have continuous coving which

presented a risk of germs collecting and was not in line with the Department of Health's Health Building Note (HBN) 00-09: infection control in the built environment.

We saw that aprons and gloves were available in clinic areas. We saw that staff used gloves and aprons when providing care and changed them after cleaning wounds and before providing further treatment. Staff removed aprons and gloves after providing care.

Staff told us that in the event of an infectious patient attending, they would use the individual treatment rooms

instead of the bay to mitigate risk of cross contamination. Five of the seven clinics were in individual treatment rooms hired from GP medical practices and patients at the Horsham clinic were treated in individual treatment rooms.

We observed sinks in treatment areas. The sinks had elbow controlled taps that did not pour directly into the drain. This complied with Health Building Note (HBN) 00-09: Infection control in the built environment.

We found equipment was visibly clean throughout the department and we observed equipment such as treatment couches and chairs being cleaned in between patient use. The service did not use 'I am clean' stickers to signify that equipment had been cleaned as they felt this could leave a residue which could pose an area for germs to adhere to. Instead, staff relied upon a cleaning checklist on the inside of cupboard doors of each clinical area which was to be completed daily. Although we saw that these checklists were regularly signed and equipment appeared visibly clean, staff could not be confident that the equipment had been cleaned prior to use.

We observed that chairs in some clinic waiting areas, were not covered in wipe clean fabric. This meant that some furniture could not be easily cleaned by cleaning regularly with wipes and could pose and infection control risk.

We saw that clinical waste bins were labelled and used different coloured bags to signify the different category of waste in all of the areas we saw. This was in accordance with Health Technical Memorandum (HTM): Safe Management of Healthcare Waste, control of substances hazardous to health (COSHH), and health and safety at work regulations. However, we saw that none of the non-clinical waste bins were labelled and not all of them contained bags. Whilst not an immediate risk, this could mean that staff or patients could dispose of waste incorrectly.

We saw results of quarterly waste audits which demonstrated 100% compliance throughout the last four audits. However, we noted from a spot check audit carried out in February 2017, a clinical waste bin was found to be overfilled and immediate action was taken to address this. We saw the areas for storing waste at the various clinics were secure with locked bins secured to a wall, this prevented unauthorised access to waste.

We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We checked eight sharps bin containers and all were clearly labelled to ensure appropriate disposal and traceability. One sharps injury was sustained in 2017 and we saw that an incident report had been completed and occupational health policy followed.

We reviewed current cleaning schedules which reflected that rooms and equipment had been cleaned in all but one instance. When rooms were not in use there was a line through the day to indicate that cleaning was not required. When we asked staff about the day where a room had not been cleaned they told us that the room was not in use that day but that staff had failed to put a line through the entry to indicate this.

Staff told us that they did weekly deep cleaning within the clinics. They told us that they did not keep a log of the cleaning but that it was recorded in clinic meeting notes. We reviewed notes for December 2016 and saw that cleaning was recorded for the weeks of 15 and 29 December 2016. Staff told us that it was a new system but the cleaning had taken place, even if it was not recorded. This meant that staff could not be assured that the cleaning had taken place.

Mandatory training

The target completion rate for mandatory training across the organisation was 100% but the actual compliance rate was 81%. Manual handling had the lowest level of compliance at 32%. Other low scoring training modules were safeguarding, infection control, stress awareness, health and safety and fire safety.

Mandatory training was delivered by an external company, and future dates were booked for all members of staff on the mandatory training tracker document, which we saw. This meant there was a plan to address poor compliance with mandatory training. The frequency of certain training modules, such as safeguarding, had recently been increased from three yearly to yearly to fall in line with national guidance and this had contributed to the low overall compliance. Managers were aware of this and had a plan which ensured they would be up to their target compliance within six months.

Assessing and responding to patient risk

One of the tissue viability nurses (TVN) reviewed incoming referrals and would flag any referrals that were inappropriate or incomplete. We saw that during 2016, 63 inappropriate referrals (6%) were received for the

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Eastbourne sites, and 39 inappropriate referrals (5%) were received for the Crawley, Horsham and West Sussex (CHWS) sites. In the event of an inappropriate referral the TVN returned the referral and requested further information. If a patient arrived in a wheelchair, their level of mobility would be reviewed on arrival. If they could not walk and transfer from a chair to a bed they would be referred back to their GP in line with the referral policy.

The centre at Eastbourne had recently installed defibrillators. There had been no recorded incidents of any patients collapsing whilst on site. However, staff were able to tell us occasions where a patient had appeared unwell and they had either called an ambulance or made an urgent referral to the GP. We saw an incident report was completed when this occurred.

We saw that basic life support training (BLS) formed part of the organisation's mandatory training, and that 100% of staff had completed this training.

Staffing levels and caseload

There were no staff vacancies as of the 24 February 2017.

No clinical agency staff were used by the provider. The provider has recently started a staff bank. One nurse has been recruited into the bank and applications are open via the provider website.

Clinical staff were made up of Tissue Viability Nurses (TVN), Tissue Viability Nurse Consultants (TVNC) and Clinical support workers (CSW).

We reviewed staffing levels between October 2016 and February 2017 and observed that actual staffing levels fell below planned on two occasions, due to staff sickness absence and parental leave. Staff told us they felt they had enough staff to do their job well. There were discussions in one of the locations regarding the addition of a clinical support worker to join a TVN which staff felt could improve the efficiency of the clinic.

Managing anticipated risks

The provider had an in date adverse weather policy, which stated that in the event of a weather warning, staff must identify risks as early as possible before the start of adverse weather. We saw an email trail advising staff the day before an expected adverse weather day of arrangements for texting the director before 8am if unable to attend in order to cancel any clinics.

There was also a driving at work policy which gave staff advice on how to minimise risks whilst driving in adverse weather conditions. This ensured staff who carried out domiciliary visits as part of their working day had a clear policy to refer to.

Major incident awareness and training

Fire safety drills and training formed part of the mandatory training. We saw the Eastbourne fire drill log book. It showed that fire drills were required one to two times per year, that the location had had two drills in the past three months, and that all people present were evacuated in under 4.5 minutes. This meant that the location was meeting its targets for fire drills.

We looked at two fire extinguishers which were both in date and saw that fire alarms were to be tested weekly, although there was no log to record the testing. We saw that there were paths to fire exits that were clearly marked with green fire exit signs.

There was an emergency policy, which cited the clinical director as the responsible person in the event of an emergency.

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 of findings

Summary

- Services were delivered in-line with current national guidelines and were monitored to ensure compliance.
- Patients had comprehensive assessments of their needs and were included in decision making and wellbeing.
- We saw evidence of effective multidisciplinary working; teams worked collaboratively to understand and meet the range and complexity of people's needs.
- Appropriate awareness and training in the Mental Capacity Act and consent was seen and staff understood their roles in relation to this.

However:

- Not all staff had a current appraisal due to a recent change in appraisal methodology.
- Staff did not always update patient records to reflect the reason for clinical decisions.

Our findings

Evidence based care and treatment

Care and treatment was delivered in line with current legislation and nationally recognised evidence-based guidance. Local policies, such as the infection control policies were written in line with national guidelines. Staff we spoke with were aware of these policies and knew how to access them on the intranet.

We saw meeting minutes, which confirmed monthly meetings included NICE guidelines and compliance was discussed and monitored. Healogics used an evidence based approach based called 'HealSource' which was produced by the American branch of Healogics and was trademarked. The version used in the UK had been edited to reflect a nurse led approach and comply with UK guidance. It contained a nine step approach to the assessment and management of wounds.

The Heal Source document referenced several National Institute of Health and Care Excellence (NICE) guidance including Surgical site infections: prevention and treatment (CG 74) Diabetic foot problems: pre Diabetic foot problems: prevention and management (CG 19), Healthcare-associated prevention and control in primary and community care (CG 139) and Pressure ulcers: prevention and management of pressure ulcers (CG 179). We observed staff following these guidelines in clinic during our inspection.

Staff performed ankle brachial pressure index (ABPIs) in line with Royal College of Nursing guidance. The ABPI is a diagnostic tool used to define the wound and decide whether a patient should receive high compression. The guidance states that assessments should be completed at 3, 6 or 12 month intervals depending on initial and ongoing assessment, outcomes, cardiovascular risk profile, patient needs, or according to local guidelines and we saw that the assessments for these were often completed. However, when they were not completed, we did not see the reasons for not performing ABPI consistently recorded.

The patient records also reflected that staff did not always apply compression in accordance with guidelines. Staff explained that they weighed several factors when considering the amount of compression to put on a wound. They considered patient comfort, specific blood pressures (ABPI) and the ideal compression against the patients not complying with recommendations if dressings were too uncomfortable. Staff explained that in some cases they slowly increased compression so that patients could tolerate the level of pressure. However, not all records we reviewed reflected a discussion of pain and ABPI or an analysis of why particular compression levels were used when they were outside of national guidelines.

Pain relief

Staff at the centres were not able to prescribe pain relief and did not have access to analgesics (pain killers) or other medicines on the sites. Any patients that reported pain or needed support regarding their pain would be referred back to their GP. If urgent pain relief was required, staff could access GPs within the practices they were based in.

We spoke to staff about ways of managing pain during the procedures. Staff told us pain scores were completed at initial assessments and reviews. We saw pain scores were

completed in some of the records we reviewed. However, three records we reviewed did not record patient pain levels. This meant it was not clear that staff was always asking patients about their pain levels.

Staff told us that if a patient was finding a procedure painful or uncomfortable they would allow extra time, and on three of the feedback cards we reviewed, patients commented that the staff were gentle with their wounds and one commented that although they found the initial assessment painful, staff did "everything possible to make them as comfortable as possible."

Nutrition and hydration

Staff told us that good nutrition was essential for the promotion of wound healing and they used a malnutrition universal screening tool (MUST) to help identify patients who were malnourished or at risk of malnutrition. We saw in ten sets of patient notes that staff had assessed patients using MUST at the initial consultation and in ongoing reviews.

Staff told us about providing holistic advice, including nutrition advice and giving each patient the time they needed to discuss and receive care. Patients we spoke to reiterated that they always received the time they needed. We saw nutrition information leaflets available for patients in patient waiting areas.

Patient outcomes

We saw that the provider undertook local audits in 2016. An example of this was a local venous leg ulcer audit which was based on National Sentinel Audit Project for the Management of Venous Leg Ulcers (2000) and adapted by Healogics using Management of Chronic Venous Leg Ulcers, A National Clinical Guideline published by the Scottish Intercollegiate Guidelines Network (2010), Healthcare Improvement Scotland. The 2016 audit was carried out on 20 patients and achieved a 93% compliance rate, which was better than the previous year's score of 84%. An action plan was red, amber, green (RAG) rated for areas of non-compliance and these had dates by when should be completed by. This meant there was a plan in place to improve compliance.

The provider had planned to complete a diabetic foot ulcer audit based on the NICE NG19 guidance, however there were too few patients on the caseload to successfully audit in 2016.

The provider also conducted a patient quality of life and expectation survey in 2016. This survey asked 27 patients questions relating to various aspects of the patients life at the initial consultation, and then four weeks later, to assess whether any improvements had been made. When asked regarding the physical limitations of their wound, the results showed that significant improvement were made regarding swelling, healing, irritation and odour of the wounds. However there was less significant improvement in terms of pain, which the provider had logged as a follow up action.

The provider was developing a performance dashboard. Information from the most recent dashboard provided reflected that in the first and second quarters of 2016 there were 123 and 128 mean average days to healing. This was generally in line with the healing rates reported from 2015.

In 2017 Healogics reported a 7.8% wound infection rate across the Healogics service. There was not a target in place for infection rates but the provider told monitored compliance to ensure quality of patient outcomes could be measured.

A small number of patients wounds would not heal. These patients could be put on a maintenance pathway so that the patient could continue to receive care if they wished. To offer this service on the NHS, the provider had to apply to the relevant CCG for each individual patient.

Competent staff

As of September 2016, 71% of staff at the Eastbourne clinic had an appraisal within the last twelve months, and 0% of staff had an appraisal in the CHWS team. This was worse than the provider target of 100%. Senior staff explained that they had recently started using the NHS guidance on appraisals. This meant that staff were more involved in the appraisals and they focused on specific core areas of staff performance. It also meant that some staff had gone over the 12 month time frame in order to apply the new appraisal structure. Staff told us they found their appraisals useful and gave examples where they had identified training needs such as on database management.

Registered nurses are required to revalidate their nurse status with the Nursing and Midwifery Council every three years. We saw an electronic tracker that flagged up when members of staff were approaching their re-validation date,

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prompting the administrators to send an email reminder to those staff members. All members of registered staff were up to date with their revalidation at the time of our inspection.

One of the tissue viability nurse consultants were educated to degree level in tissue viability. One had a masters degree in wound healing and tissue repair and one was due to embark on the same course in 2017.

We saw competency documents for staff in leg ulcer assessment and management and in wound assessment and management. This meant that staff had been assessed by a senior staff member as having the skills and knowledge to carry out these tasks.

Staff were required to demonstrate their competency to provide Lymphodema care. Staff told us that registered staff (Nurses and Podiatrists) took the two week Lymphoedema course at the Lymphodema Training Academy (LTA) which was followed by theory and practical tests including assessment of specialist bandaging techniques and Manual Lymphatic Drainage.

Staff told us some Health Care Support Workers had also attended a course for Associate Lymphoedema Practitioners at LTA and have done a further four day training course at Healogics.

There were annual updates to the practitioner course and all Lymphoedema Practitioners and Associate Lymphoedema Practitioners undertook a specific lymphoedema competency assessment annually.

All new members of staff had their four day induction at the Eastbourne clinic. This allowed new members of staff to meet members of the senior and administrative team who were based there. We spoke to staff who told us they felt welcomed and supported by the team during their induction. New starters also received a staff handbook which included information about values, whistleblowing and signposting, and policies.

Multi-disciplinary working and coordinated care pathways

Staff told us that they worked with other healthcare professionals in the community and we saw in the period 2016, 363 joint visits were carried out with the district nursing team.

Five of the seven 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 Healogics 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.

The provider carried out a peer satisfaction survey with the Crawley, Horsham and Mid-Sussex (CHMS) referrers for 2016 and 2017; 11 GP practices responded. The practices gave positive or neutral responses to eight out of nine questions. There was a 5% 'disagree' response to the statement 'Healogics is easy to contact.'

Staff told us they had a developing relationship with a local diabetic foot lead. They had open communications and one staff member had arranged to spend a day shadowing the diabetic foot lead so that they could learn more about each other's practices.

Referral, transfer, discharge and transition

The main route of referral into the service was via the patient's GP. Patients were also able to self-refer and access the service privately. Once assessed, staff entered patients onto one of two pathways consisting of 12 or 18 weeks of care. There was a further maintenance pathway for patients whose wounds had primarily healed but benefited from ongoing treatment to help patients maintain good skin health.

Once a patient's wound was sufficiently healed, they were referred back to their GP for routine follow up.

Access to information

All patients were seen with their notes, or if an initial consultation, with the information provided on the referral form. A nurse acted as triage for incoming referrals, and if insufficient information was on the referral form, this would be referred back to the referrer. The GP also provided further information from the electronic patient information system used in GP surgeries, if required.

Staff that travelled to different clinics (CHWS area) based in GP surgeries attended the Horsham office where they collected patient notes, and these were then transferred in lockable wheeled cases. In the clinics records were stored in locked cabinets. This meant patient records were held securely.

The administration team provided the reception staff with a daily list of patient names and appointments that were expected, in order that the patient could be correctly

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.

directed to the correct clinic room. Reception staff told us they checked for test results before appointments so they could give any new information to the staff caring for the patient. We spoke to the GP receptionists who advised that this system worked well.

Staff could access internal policies via a web-based system. All staff had a log on, and could view upcoming rotas, policies, appraisal and revalidation data.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

We reviewed 16 sets of patient records. Of these, 100% had consent documented for routine wound care and consent for photographing the wound. However, on two consent forms the clinic location was left blank.

There was a separate consent form used for sharp debridement, this is the removal of non-viable (dead) tissue from the wound surface using a sharp instrument. We saw the blank form used which outlined the risks and benefits of this procedure. Staff told us they discussed sharps debridement with patients and asked for verbal consent at every appointment as their willingness to have the procedure could change.

Mental Capacity Act (MCA) training was part of the mandatory training. We saw that 96% of required staff had completed this training. This meant that only one member of staff had not completed this training (23 out of 24 eligible members of staff).

Are services caring?

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

Summary of findings

Summary

- Feedback from patients and their relatives was continually positive. We witnessed staff gave patients the time to listen to their concerns and offered support where needed.
- Staff explained and ensured that patients and carers had a good understanding of procedures before undertaking them.
- Staff showed kindness and compassion, they respected patients dignity at all times and were sensitive to patients' needs.

However:

- Privacy and dignity could not be maintained in the bay area of the Eastbourne clinic .

Our findings

Compassionate care

At the Eastbourne clinic there was a bay area where up to three patients could be treated at any one time. The bay area was separated only by disposable curtains, and as such conversations could be heard from one treatment area to another. The bay was also in close proximity to the reception area meaning that reception staff could be overheard talking on the telephone during a patient's treatment. This did not provide privacy and dignity to patients. Staff at the clinic were aware of the privacy issues that this could cause, however, patients advised staff that they enjoyed the 'banter' of being in this bay area, and often requested to be treated in this area rather than in the separate clinic rooms that were available.

We spoke to reception staff who advised that if they needed to make any personal calls to patients that they would ask a colleague to cover the main reception desk whilst they made the call from one of the offices on the first floor.

The provider has now moved from the Eastbourne site thus this issue may have been addressed. However, as noted above, we are required to report on what we saw on the day of inspection and unable to report on a site we have not seen.

Feedback from patients who used the service was continually positive about the way staff treat people. Patients reported that staff went the extra mile and the care they received exceeded their expectations. We reviewed 52 feedback cards completed by patients. All 52 were positive about the care they received. Some excerpts included "staff have magic hands"; "very caring"; "professional". Other comments included: "I feel I have got to know my clinician very well"; "I wish I had known about Healogics before so encouraging to get wounds closing in months instead of years" and "staff had a thorough understanding of the treatments and underlying principles."

One patient said, "my doctor sent me here, thank God" and explained that they had helped to heal wounds that they thought might not heal.

Every interaction we saw between patients and staff was positive. Relationships between people who used the service and staff were caring and supportive. These relationships were highly valued by staff and promoted by leaders.

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. We saw staff in a variety of roles interacting with patients in a respectful and considerate manner. Non-clinical staff members told us they welcomed patients into the clinic by name to make them feel comfortable and welcome. We saw all staff using patients' names. Care and conversations we observed reflected that staff and patients knew each other and had an ongoing relationship.

There was limited parking at the Eastbourne clinic so patients were often picked up by friends or family at the curb outside. Staff told us they helped patients out to the curb and waited with them until their transport arrived.

The patient quality of life and expectation survey in 2016 results reflected that significant improvement was seen relating to patients' ability to undertake usual activities, feelings of social isolation, and feelings of anxiety or depression.

Are services caring?

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Understanding and involvement of patients and those close to them

Leaflets containing general information about the service were available for patients. These contained relevant information such as what to bring to their first appointment, how long it may take and useful contact numbers. We saw staff explaining these leaflets to patients.

The staff handbook contained information about offering chaperones to patients and we saw chaperone signs in the clinics.In one of the satellite clinics, only one nurse was working from the GP practice. Staff told us that if a patient had requested a chaperone in advance of their appointment, they would ensure that a second member of Healogics staff was present. If a patient requested a chaperone on the day, staff would request assistance from a member of the GP practice to act as a chaperone.

Patients confirmed that they were very involved in their own care. Patients we spoke with demonstrated detailed knowledge about their conditions talked about their care and its challenges. Patients told us staff took time to answer all of their questions.

Staff told us they discussed care including sharps debridement with patients and asked for verbal consent at every appointment. They told us about a patient who consented sometimes and not other times. Staff explained that this was part of patient-led care.

One patient told us that they appreciated the continuity they had when they saw the same nurse most of the time. This meant that the nurse understood the patient and the patient understood his care.

Emotional support

Staff understood the impact of a person's care, treatment and condition on their wellbeing. Staff described talking to patients to understand their goals for care and using these to help motivate patients. For instance, one patient wanted to walk into their Christmas party and another wanted to be able to get into their car. Staff used these goals to inform care and motivate patients.

Patients reported that they built relationships with the staff. One patient highlighted that he valued the continuity of seeing the same staff members most weeks.

One staff member described how they discussed compression with patients. They explained that compression could be uncomfortable but that they educated patients about the benefits of compression in wound care. Staff included the patient's input when prescribing a level of compression, often increasing it with time, because they recognised that if a patient was uncomfortable, they might not continue with care.

Are services responsive to people's needs?

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

Summary of findings

Summary

- The provider was flexible and delivered care to meet the patients needs.
- There was continuity in patient care. Patients generally saw the same staff members who knew them and their care needs.
- The needs of patients were considered and used to make changes to the service. Urgent needs were catered for and waiting times and delays were minimal.
- Staff were able to schedule appropriate time for each patient dependent on their needs, and understood that when more time was needed adjustments could be made to ensure appropriate care was given.
- Complaints were treated fairly and with compassion and taken seriously.

However,

- Patient complaints, comments and feedback were not defined and staff demonstrated lack of clarity about how to classify patient comments. This could result in patients' concerns not being classified and responded to appropriately.

Our findings

Planning and delivering services which meet people's needs

Information about the needs of the local population was used to inform how services were planned and delivered. The service was commissioned by Clinical Commissioning Groups (CCGs) to offer the care patients needed. For instance, all of the locations provided wound care but only some sites provided lymphoedema care. Senior staff told us they had identified areas where, they believed, more wound and lymphoedema care was needed. They planned to tender for contracts in these areas.

The provider also offered their services to self-paying patients. Self-paying patients could get the same care provided to NHS patients as well as some other services such as manual lymphatic drainage which is a technique used to massage patients with lymphoedema. We spoke to staff about how self-paying patients were advised of treatment costs. We saw that there were set rates for initial assessments and follow up reviews and we were shown leaflets that were sent out to patients who enquired about this. This meant patients were informed of the cost of their treatment.

The provider ensured flexibility and continuity of care. Patients could get care in five locations in the south east at times that were convenient for them. Staff told us they would see patients at times and places that were convenient for the patient. For instance, staff saw one patient at their GP practice as their mobility scooter could not fit in the Eastbourne office. Staff explained that they accommodated patients who wanted to be seen at a specific time or needed longer appointments.

The provider identified patient needs through written and verbal feedback. They used the information to decide how services were planned. For example, the provider had stopped using buckets to bathe patients' legs prior to bandaging. One patient complained that they preferred to have their legs bathed in the buckets. The provider risk reviewed the use of buckets to decide they could use them for patients who wanted them. Based on this decision, they bought new buckets for this purpose.

Five out of the six clinics we visited were suitable for the services that were delivered. For instance, the Horsham clinic provided enough space and it was appropriate for staff to work and patients to receive care in a way that maintained privacy and dignity. The location had individual treatment rooms where staff provided care in private. Additionally, the building had parking on site so that patients who could not walk easily could easily get to the clinic.

However, the Eastbourne clinic did not always provide patients waiting for appointments with privacy and dignity. It had one official waiting area in the reception. There was also an enclosed porch where patients could wait before the clinic opened, the provider told us that this was not an official waiting room but rather a protected place for patients to wait for the service to open.

We saw patients waiting in the porch space before the clinic opened and during the day. The space opened

Are services responsive to people's needs?

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directly onto the road. This meant that patients did not have to stand in the elements waiting for the office to open. However they were exposed to weather and passing traffic each time someone entered or left the building.

Further, the building and care space were not appropriate for the services that were planned and delivered. For instance, the patient who needed a mobility scooter could not be seen in the Eastbourne clinic because the scooter could not access the site.

There was no parking at the Eastbourne clinic. This meant that patients who could not walk easily had to have someone drop them off and pick them up from the clinic and in some cases stand waiting for their taxi or to be collected by a relative.

The provider has now moved from the Eastbourne site thus these issues may have been addressed. However, as noted above, we are required to report on what we saw on the day of inspection and unable to report on a site we have not seen.

The spaces in doctor's surgeries included a clinic room and lockable storage space. These rooms were private and provided enough space for staff to work and keep necessary supplies. However, these spaces were furnished by the surgeries and used by the surgery staff when Healogics was not present. This meant, supplies for other services were stored in the room and furnishings were not chosen by the provider. For instance, when we questioned chairs in a clinic room that were covered in a non-wipe-able material, staff told us the chairs belonged to the surgery. This meant that the provider did not have control over furnishings or the space.

Equality and diversity

The provider had an equality and diversity policy which was due for review in May 2017. The policy put the legal requirements of the Equality Act 2010 into the provider's policy and practice. Additionally, the provider had a 2016 - 2017 plan to improve equality and diversity for staff and patients. It identified nine equality outcomes which it wanted to meet and actions to reach these outcomes.

One action was to ensure that the human resources department monitored protected characteristics as part of the recruitment process. In 2016, Healogics updated recruitment procedures to follow the NHS recruitment check standards. Since then, applicants who were offered a job have been asked to fill out an equality and diversity form.

An audit of the forms showed that the provider had asked for equality and diversity information from 13 new staff members. The auditing meant that the provider was aware of whether staff had protected characteristics.

The training tracker showed that 96% of staff had completed their equality and diversity training; one staff member had not done the training.

We spoke to staff about the need for translators for patients who did not speak English. Staff told us if a patient needed a translator, it would be flagged at first referral. We saw that staff could access interpreters. Staff were able to provide some interpreting services via a third party company and we saw information about interpreters on the staff bulletin board in the Horsham office. Staff told us that they had not needed to use an interpreter but knew how to access them if necessary.

Meeting the needs of people in vulnerable circumstances

Staff explained that patients had to meet certain criteria to be eligible for care and treatment. For instance, patients had to be ambulatory (able to walk with or without assistance) to receive care in the provider's clinics. To meet the criteria, patients did not need to walk long distances but needed to be able to get into the clinic (unaided, with walking aids or using a wheelchair) and transfer onto the chair or couch. The clinics were wheelchair accessible and staff were able to raise and lower chairs and couches to meet patients' needs.

Staff explained that they did not assist patients to transfer. If patients needed more help moving, staff did not provide physical assistance but allowed carers to do so.

Staff told us if patients did not meet the conditions, they would be referred back to the GP for a referral to an appropriate service.

This could mean that a patient without a carer might not have the same access to care as a patient with a carer. However the provider told us that non-ambulatory patients would be seen by an alternate provider or at a GP clinic or home depending on their location.

Are services responsive to people's needs?

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

Staff told us that they would go to a GP practice to provide care or meet with the GP if it was possible and necessary. This meant that if a patient was not able to come to the clinic, in some cases staff could see them at their GPs office. Additionally, staff told us one tissue viability nurse (TVN) visited some patients in their own home or rest homes. The TVN visited these patients with a community nurse. This meant that more patients could benefit from the TVN's expertise.

We saw bariatric (patients with a high body mass index) couches in some treatment areas and bariatric chairs in some waiting rooms. Staff verified that the bariatric furniture was in some, but not all of the facilities. This meant that bariatric patients could be limited to which site they could be treated in.

Staff told us they provided holistic care which looked at the patient's other diagnoses, emotional health, eating, lifestyle and individual needs and interests, as well as physical health. For example, staff explained that it was common for some of their patients to have depression. A staff member described how building a trusting relationship with the patient was part of holistic care that helped with care and concordance (following the treatment plan).

Another patient had a condition which made it difficult for them to come to the clinic regularly. Staff were able to arrange for the patient to be seen by district nurses twice a week and only come into the clinic once a week. The patient felt this was acceptable and agreed to the plan.

Staff explained that some of their patient population who were living with addiction or psychological conditions did not always attend appointments. In these cases they would explain the importance of concordance and why they needed to come to appointments. They would contact the GP and tailor care to help patients as much as possible by seeing them when they did attend.

Staff received dementia training. Staff told us that they used this training to understand patient's needs, make them comfortable and understand how to interact with patients living with dementia and their families. One staff member described seeing a patient who was living with dementia. The patient looked neglected so the staff member contacted the GP. The GP was able to get the support the patient needed.

Access to the right care at the right time

Patients told us that they had been able to get appointments in an acceptable timeframe. Two patients explained that they had received appointments within two weeks, one patient was able to reschedule as they were unable to attend. Another patient told us that they had, 'gotten right in.'

Patients told us they saw TVNs for dressings regularly and that the appointments were convenient and easy to schedule. Patients who preferred appointments at a specific time of day told us they were able to schedule the appointments when they wanted them.

Patients told us that they usually scheduled appointments in person but they could call the office to schedule if they wanted.

The provider told us that between April 2016 and February 2017 they had a 4% cancellation rate. They explained that they did not record data about rescheduled appointments. They told us when Healogics cancelled an appointment; another member of staff could usually see the patient on the same day. This meant that patients were usually still seen at their scheduled appointment time, but by a different staff member.

However, the provider reported that they were not meeting the target times for referral to initial assessment times. The local targets for wound care were three days for very urgent cases and 10 days for urgent cases for the Eastbourne, Hailsham and Seaford Clinical Commissioning Groups (CCG). The provider met these targets in 82% of cases at the time of reporting. They improved to 93% compliance during the period from January through March 2017.

The national targets for lymphoedema were 28 days for very urgent cases, 56 days for urgent cases and 70 days for non-urgent cases. The provider met these targets for patients from the Eastbourne, Hailsham and Seaford CCG in 89% of cases and from the Hastings and Rother CCG in 79% of cases at the time of reporting. They improved to 100% compliance for both CCGs during the period from January through March 2017.

Healogics explained the addition of lymphoedema care to their contract, without significant notice, had put a strain on the service creating capacity issues for patients from the Eastbourne, Hailsham and Seaford Clinical Commissioning Groups (CCG). To address this, they appointed tissue viability nurses who had undergone training. Additionally,

Are services responsive to people's needs?

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they had appointed two new HCSW's to train in the role of Associate Lymphoedema Practitioners. The provider reported that as a result, they saw significant improvement in referral to wound care treatment times in the last quarter of 2016 and were meeting their targets with regard to lymphedema referral to treatment times from January through March 2017 as described above.

The local targets for wound care services provided to patients from Crawley CCG and Horsham Middlesex CCG were less than 11 days. The provider met these targets in 56% and 62% of cases, respectively during the reporting period and 60% and 61% of cases, respectively, from January to March 2017. The provider reported that they were hiring and training staff and extending hours to address the waiting times. However, at the time of inspection, patients were waiting longer than the local targets to start treatment which could impact their wellbeing and outcomes.

The provider explained that the only other provider in the area had only been able to provide a very limited service over the past six months causing a 33% increase in patient numbers for Healogics. To address this influx, Healogics had increased the Crawley clinic services from two to five days a week and extended hours to 6pm. The Horsham clinic was taking some of the overflow and they were recruiting staff to meet the demand.

We spoke to staff about patients who missed their appointments and the process following this. Staff told us that it was obvious when their patients did not attend (DNA) due to close working relationship they had with the patients. In the event of a DNA, staff would first try and contact the patient directly. If unable to make contact, they would contact the GP. The organisation monitored the number of DNAs, and during 2016, the EHS sites had 96 DNAs (1.3% of all appointments) and the CHMS sites had 95 DNAs (1.2%) of all appointments. This meant there was an overall DNA rate of less than 2%.

Learning from complaints and concerns

The provider had a corporate complaints policy that was due for review in July 2017. The policy required employees who received an 'informal complaint' to report it to a TVN and try to resolve it. If a patient made a 'formal complaint', the provider was to acknowledge it within three working days and respond in 20 working days. However, there was no definition of an informal or formal complaint in the policy.

Under the complaints policy, services users were able to raise complaints or concerns verbally or in writing. We saw patient feedback cards in the clinics and a complaints policy in some clinics. However, there were no complaints specific forms and there was no opportunity to make complaints or comments using the website.

The complaints tracker reflected that in practice service users reported complaints, concerns and feedback verbally, or in writing (by letter, patient survey, or use of the clinic suggestions box) eight times during the reporting period.

The provider reported that it had received no formal complaints in the year prior to our inspection. However, the provider's complaints tracker reflected they received one verbal complaint, two concerns and five pieces of negative feedback although the differences between these kinds of feedback were not clear.

There were no clear trends reflected by the complaint, concerns or feedback. They addressed issues including care, communications, timeliness and services offered.

The complaints tracker showed that the verbal complaint was about an interaction between a staff member and a patient's carer that had upset the patient. A statement was taken from the staff member about the incident. The learning about how staff should managed disagreements with carers was identified. The learning was shared with staff, customer service training was offered to staff members in December 2016 and conflict management training had been added to the induction program. This showed that the provider learning was taken and shared from the incident.

Staff investigated patients' concerns fully. There were two cases where the patients had requested a change to services. The provider considered the benefits of these requests and made the change in one case. In the other case, they found they were not able to provide the service requested but agreed to review the matter again after they moved to a new location.

Staff told us that some feedback highlighted areas where changes or training was appropriate. In one case the provider organised a training session so that local TVNs could learn about the lymphoedema services they offered.

Are services responsive to people's needs?

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When there was a complaint about hosiery delivery (which was already a known problem) the provider reviewed and changed the process for ordering, storing and delivering hosiery.

We reviewed the two files that addressed negative feedback which might have been considered a complaint. In both cases the issue was fully investigated, patients received feedback and lessons were shared with staff.

However, the difference between complaints, concerns and feedback was not clear. The terms were not defined in the policy and staff used the terms negative feedback and complaint to define the same incident. This could create confusion and meant that patient complaints might not be recorded or replied to in line with the corporate policy.

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 of findings

Summary

- There was a clear governance structure with communication to the executive team. Staff felt supported by their line managers and felt confident to raise concerns with them. There was a strong visible local leadership who together with the staff were committed to improving patient care.
- We saw staff and managers shared the same vision and strategy and staff survey results reflected this.
- Risks were regularly reviewed by the senior team and staff were able to describe the risks to the organisation.

Our findings

Leadership of this service

The service was led by the managing director who was supported by the senior management team and two regional team leaders. The provider's SMT members and main administrative services were based at the Eastbourne site.

The south east region was separated into two geographical teams, each team was led by a tissue viability nurse consultant.

Staff working at the Eastbourne clinic and those who worked remotely told us they knew the SMT and could ask them for support and advice. Staff told us they regularly interacted with senior managers. They described SMT as 'supportive', 'approachable' and 'fantastic'. They knew which area each senior manager was responsible for and how to contact them by phone or e-mail when needed.

Staff in the Eastbourne team were based in the same building as the SMT and told us they interacted with them regularly, which we observed during our inspection.

Staff who worked in the regional clinics told us that they saw members of the SMT on a regular basis. They told us that one of the senior managers always came to their team meetings, which were held every other week. In addition, the clinical manager visited the Horsham clinic on a weekly basis. One member of staff told us that they had not seen senior management in a smaller clinic in the past few months, although they saw them at the meetings regularly.

Staff in the clinics outside of Eastbourne told us they were connected to the other sites and felt connected to the team and organisation as a whole.

Both team leaders were new to their roles, having been in post for under a year. Both demonstrated they understood the challenges to providing care and how they had worked to address these challenges.

Team leaders explained that they had brought different skills and knowledge to the role. They told us that they each had the necessary experience and knowledge to lead the team but that they could turn to the clinical director or other clinical members of the senior management team if needed.

Staff said that the team leaders were skilled, visible and approachable. The teams were small and staff said that they had a lot of regular contact with their team leaders. They told us that they turned to the team leaders for clinical advice when they needed it. Staff received support from the team leaders in line with their own needs and experience.

Service vision and strategy

The service had a clear vision which was shared across the business. The vision was to drive 'wound science, healing and prevention forward to heal more wounds and change more lives.' Staff we spoke to understood this vision and felt that they had a role to play in it.

Staff told us about patient-centric and holistic values. They told us that they felt the provider's vision and values were shared with staff and they felt supported and included with regard to the corporate vision. We spoke to managers who told us that the values were explained to staff attending for interview, so that from an early stage staff could be aware of the values they would be required to uphold.

The corporate mission was to advance wound healing by creating and sharing wound care expertise everywhere they could, for every patient who would benefit, by the best means available. They have developed six strategic objectives to fulfil this mission.

The business within the United Kingdom (UK) was growing. Staff explained that they were looking at adding more

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services to some sites and expanding. In summer 2017, the provider was planning to move its headquarters. The new site was to be more accessible to patients, larger and provide treatment rooms where patients' privacy and dignity will be maintained.

Governance, risk management and quality measurement

The provider was a United States (US) based company with UK locations including the six locations we involved in our inspection. The UK managing director had overall responsibility for the UK services whilst working closely with the US business.

The provider was governed by UK legislation and regulation. The provider contracted with UK solicitors and consultants to ensure that it was compliant with UK law and regulation. The provider's policies and processes were based on the company's US materials but had been altered to comply with UK legislation and practice.

The clinical director was the head of clinical governance, they reported directly to the managing director. The clinical management team (CMT) and senior management team (SMT) supported the head of governance and reported directly to them. The TVNs reported to the TVN Consultant within their team.

The SMT oversaw day to day business and management processes, defined the culture and disposition of the provider and ensured that systems were in place to identify and manage risk.

The CMT provided a group where senior consultants and the SMT could discuss matters including incidents, quality improvement, compliance, training and development, policies and adherence to National Institute for Health and Care Excellence (NICE) standards.

The provider had a risk reporting system that staff reported they used. This information was reviewed by the team manager for each location and raised with the head of governance as necessary.

The provider had a risk register, senior staff were able to tell us what risks were on the risk register which were generally aligned with the risks identified during the inspection. , and addressing, Issues with the flooring, safeguarding training and equal access for patients without carers were not on the register, although training more generally was.

There was a holistic understanding of performance which integrated safety, quality and financial concerns. Staff told us that safety always came first and profit would not come before safety. The risk register provided evidence to support this. It showed that the provider withdrew from negotiations when the CCG involved insisted on using supplies which the provider believed would result in poor patient care.

The provider gathered information and data which enabled them to measure quality of the care provided. This included a number of audits, for example, patient records audit, quality of life audit, NICE venous leg ulcer audit.

Additionally, the provider collected data and reports quarterly on Key Performance Indicators (KPIs) to each Clinical Commissioning Group (CCG). The provider's performance against the KPIs varied as reflected in previous sections.

Staff told us that the information they collected allowed them to monitor healing rates and infection rates but that it had not highlighted particular problems.

The provider did not participate in national benchmarking. However, they explained that this was because there was not an applicable national audit to use for benchmarking.

Culture within this service

Senior staff told us that they employed staff with basic skills for their ability to interact with patients and the team, not specifically for their wound care expertise. They said that staff with these skills could learn to provide wound care. This was reflected in the culture. Many staff members we spoke to did not have experience as tissue viability nurses or specific wound care before working for Healogics. As a result the service focussed on learning. Staff received training at induction, role specific training, continuing education and mentoring. Additionally, there was time allocated for training at team meetings.

We saw staff interacting with each other in an open and supportive manner. Staff explained that they worked together closely to provide patient care and support. Staff told us about a staff member with strong clinical skills and weak organisational skills who was paired with a staff member with strong organisational skills who needed clinical support. They were able to provide mutual support and mentoring.

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.

Senior staff described creating a 'just' culture rather than a 'no blame' culture. They explained that using the term 'blame' implied that someone is to blame. Staff we spoke to verified that they felt it was a 'just culture'. Staff were encouraged to report incidents. Learning from incidents was used to develop staff and the provider.

This was verified by the June 2016 staff survey results. The staff survey reflected that 96% of staff who responded to the survey agreed that they were encouraged to report errors and 4% (one respondent) neither agreed nor disagreed.

Care was patient-led; the culture was centred on the needs and experience of people who used the services. Staff used the patient's own goals to create a care program and encouraged them to stick with it.

Public engagement

The provider collected patient feedback using feedback questionnaires, quality of life questionnaires and patient comment boxes at each site.

The provider did not have a patient representation group. The provider explained that they had previously had a group but that it had not worked. They believed that this was because their patient group was not permanent. Patients were treated until their wounds healed and then were discharged or entered onto a maintenance pathway.

The provider had planned to start a group of 'critical friends'. The group had not yet started meeting. However, terms of reference reflected that it would include patients, unpaid carers, one GP representative and one Healogics representative. They would meet six times a year to ensure public involvement and partnership with Healogics.

Staff engagement

The staff survey reflected that staff were generally positive about their work, 85% to 96% of staff responded positively to questions about going to work and job responsibilities.

The provider told us that staff were encouraged to join in planning and delivery of services at meetings, consultations and through their staff survey. However, the survey reflected that staff were less positive about engagement and communication. The lowest scoring questions, not including questions about pay and benefits, were all related to engagement and communication. For example, when staff were asked about their involvement in change, effectiveness and communicating team objectives, only 68%, 69% and 65%, respectively, responded positively.

With regard to senior managers, 61% of staff felt that senior managers involved staff in important decisions and 69% felt that senior management acted on staff feedback. This reflected that, staff were generally positive about their work experience, but did not believe they were meaningfully engaged in change. It should be noted that the survey was taken seven months before our inspection.

As a result of these staff survey results, the provider reported that they had begun morning meetings before clinics when possible. We saw the notes which showed that the meetings had been occurring.

Staff in clinical and non-clinical roles told us that they felt included and encouraged to engage at staff meetings and events.

Innovation, improvement and sustainability

Senior staff told us that the business was not currently profitable, and identified this as a concern. This was reflected in the board meeting notes. However, they told us that they were responding to care needs in the community and that they would continue to grow the business by bidding for new contracts and challenging how wound care was provided by some CCGs.

The provider was working to provide telehealth (healthcare delivered via telephone or internet connection) services to deliver advice to those who might find it difficult to access care. (This service was already provided by Healogics from locations outside the limits of this inspection.)

Members of the staff and senior management team had recently published a paper in the Journal of Community Nursing about promoting patient concordance to support rapid leg ulcer healing. This showed that they had used their experience to identify challenges and drive change throughout the business and more widely.