Accelerate CIC at Mile End Hospital

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Accelerate CIC is a community interest company that provides specialist wound and lymphoedema services in Tower Hamlets and City and Hackney. It provides services to people in their own homes and sees people at a treatment centre based in each of the two areas.

Its head office is located at Mile End Hospital. It was set up in 2011, initially covering the Tower Hamlets area. Since this time it has grown from seven to 30 employees in line with contractual growth. Its current scope of practice covers:

In Tower Hamlets it provides a nurse led specialist wound service where 95% of people are seen in their own homes. There is a treatment centre on site at Mile End Hospital where the remainder of people are seen. There is also a specialist lymphoedema service which is nursing and physiotherapy led. 50% are seen in their own homes and 50% at the treatment centre.

In City and Hackney the service has a base and treatment centre in rooms rented at Saint Joseph's Hospice. The ratio of people seen at the treatment centre and in their own homes in Tower Hamlets, also applies in Hackney.

The service is open from Monday to Friday; 9am-5pm. There is a local community focus on what happens to patients at home. The services link up with other providers such as the two local NHS community health providers, GPs, nursing homes and community nursing, who are the coordinators of care.

There are specialist nurses in both wound and lymphoedema care. These are part of the wider multidisciplinary team that consists of a 0.4 whole time equivalent consultant dermatologist, a senior podiatrist, two physiotherapists, plus two contracted clinicians from a local provider; a clinical psychologist 0.2 whole time equivalent and a monthly clinic with a plastic surgeon. The multidisciplinary team practices from the treatment centres where specialist nursing is also present. Visits to people in their own homes take place where the need arises. Highly complex patients are referred from across the greater London area for assessment in the treatment centre.

As part of this inspection we interviewed senior managers including the chief executive and chair of the board. We spoke with key members of staff including specialist nurses and members of the multidisciplinary team. We requested information on the service prior to our inspection and gathered information on the day.

We visited people in their own homes with members of staff, in both Tower Hamlets and Hackney. We visited the treatment centres. We spoke with sixteen patients and carers during the inspection. We left patient comment cards with the service and invited patients to give us opinions on any aspect of their care. We received 16 comment cards back.

Services we do not rate

We regulate independent community health services but do not currently have legal powers to apply the duty to rate all of them. Our methodology for small and medium community healthcare providers is based on not rating as there are no service specific frameworks to support consistent ratings decisions. However, we do take regulatory action as necessary, highlight good practice and issues that service providers need to improve.

We found the following areas of outstanding practice:

- Staff were encouraged and supported to submit clinical and academic journal articles to national publications which was seen as a great way of sharing learning and studying a specific topic. Staff were identified for these so they fulfilled a role in the national agenda in wound and lymphoedema care.
- Staff knew their patient group, had a holistic approach to care and advised patients on whole care needs. Self care was promoted and patients were involved in decisions about their care in an exceptional way. We observed staff explaining care and treatment to patients using appropriate language, the patients' conditions and the physiology behind it. Staff respected individual choices and offered appropriate treatment choices.

Summary of findings

- There were a number of initiatives that directly involved patients and their views. The team and management were passionate about their speciality and organisational culture centred on the needs and experience of people who used services.
- The service were experts in compression therapy and fed in to NHS England work streams in wound assessment, management and working with commissioners. Education programmes took place for practice nurses in community NHS trusts looking at baseline skills and champions.

We found the following areas of good practice:

- The team and management were passionate about the speciality and the organisational culture was centred on the needs and experiences of people who used services. We observed this in practice; in the treatment centres and in the community.
- Incidents were appropriately reported, reviewed and learnt from. Relevant information was shared with other teams. Items that related to safety performance were recorded and themes identified on a tracker.
- There were good standards of prevention and control of infection through nurse practice, audit and action.
- As well as there being a team of specialist nurses, there was a multidisciplinary team who practiced from the treatment centres. We observed good working relationships between different professions and there were clear lines of communication with key professional partners such as community nursing and GPs.
- Staff understood the needs of their patient group. Difficult to treat wounds and complex lymphoedema were managed with good care planning.
- We spoke with 16 patients and relatives during the inspection and received comment cards from a further 16 patients afterwards. All were positive and complimentary about the service. Patients told us that staff were encouraging, sensitive and supportive.
- We observed nursing staff delivering compassionate care. Staff delivered care in an unrushed and holistic manner. Patients were clearly involved in decisions about their care. We observed staff explaining care and treatment to patients, the patients' conditions and the physiology behind it using appropriate language.
- The governance and reporting structure showed clear lines of accountability and clear lines of reporting from the board to clinical leads. There were clear lines of leadership accountability, with the clinical director and chief executive taking a 'hands on' approach.
- Contract review meetings recognised that the population needs were changing and that service specification needed updating to meet local needs. The service was working collaboratively with a local NHS trust that provided community health services and the local GP care group to review population needs and identify gaps.
- There were clear vision and values that had been produced by the whole team and linked to the service's strategy.

However, we also found the following issues that the service provider should consider for improvement:

- The training record did not accurately reflect what training had taken place. There was a software system used by the service to record staff training which relied upon staff manually inputting their own training attendance which had not occurred in a number of records.
- Although incorporated into assessments and covered in training, staff we spoke with understood their responsibilities for obtaining and recording consent but had limited understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Summary of findings

Following this inspection, we told the provider that it should consider making some improvements, even though a regulation had not been breached. We have not issued the provider with any requirement notices. Details are at the end of the report.

Amanda Stanford
Deputy Chief Inspector of Hospitals (London)

Summary of findings

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Community health services for adults

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Are community health services for adults safe?

- Incidents were appropriately reported, reviewed and learnt from. Relevant information was shared with other teams. An 'issues tracker' recorded items that related to safety performance. Themes were identified from the tracker.
- Staff attended annual mandatory level 2 safeguarding training for both adults and children. They were aware of how to make safeguarding referrals and who to speak to within the service if they had concerns to discuss.
- Staff made entries in notes held in people's homes as a record of their input to patients managed by the community nursing services. Entries were also made in nursing home notes. After each new assessment or significant review visit they wrote a letter to the GP to share information and to request any prescriptions required.
- Good standards of prevention and control of infection were observed through nurse practice, audit and action taken.
- There was a business continuity plan in relation to the possibility of terrorist alerts and the recent major incident related to the IT issues experienced at the local NHS trust.

However

- The organisation had grown from seven to 30 employees in six years in line with contractual growth and recruitment and capacity was identified as a key issue on the risk register. This was being appropriately responded to through scheduling and staff development. Managers of the service told us that this had worked well but remained a constant challenge.
- There was a software system used by the service to record staff completion of mandatory training. However, the system relied upon staff manually inputting their own training attendance which had not occurred in a number of the records we saw, resulting in an incomplete training record that was not an accurate record of what had taken place.

Safety performance

- Accelerate CIC was a specialist service that worked alongside and in an advisory capacity to local community teams who coordinated care. They reported back on progress and contributed to the formulation of care plans. Safety thermometer indicators were monitored by the respective community teams. In this respect, they were more likely to add to the reporting done by the coordinators of each patient's care.
- An 'issues tracker' recorded items that related to safety performance such as appointment non attendees, when care plans had not been followed by other providers and when delays in doctors' letters had occurred. Themes had been identified from the tracker. We were given an example where the issues tracker had picked up the theme of patients attending treatment centres without an appointment. The issue of inconsistent or ineffective care by another provider resulted in a new joint lower limb pathway that ensure better utilisation of Accelerate's skills and better patient outcomes.

Incident reporting, learning and improvement

- Incident reports were completed on both paper and online forms. An incident log was also completed. All incident reports were forwarded to the clinical director who risk rated them as low, moderate, high or significant and in terms of whether a root cause analysis was required. We were told that themes were identified by the clinical director as they reviewed them. We were given two recent examples where there had been a

couple of low graded incidents that showed a theme and had been resolved. One was where the service found an administrative error had led to a potential for two patients to not have been seen within timescales.
- More specific learning had also come from these meetings. An understanding that moisture lesions needed separating from pressure lesions was one, and grading of pressure ulcers was another. Both had been issues taken from learning at the pressure ulcer panel that had been taken forward for educational purposes for Stop Pressure Ulcer day. This was an annual day held in November to highlight pressure ulcers and their care.
- Staff in the service worked closely with leads in community services and they told us they felt able to communicate with other teams if they felt there were practice issues that raised concerns. If carrying out joint assessments and the community team did not show up this was also reported as an incident. Safeguarding referrals would also be made if they felt it was needed in order for action to occur.
- Incidents were discussed at clinical review meetings. Outcomes and learning from incidents were cascaded to staff in team meetings. We were told that as the organisation was growing as a service they were looking to delegate roles and responsibilities more. As a result, specialist practice nurses and other staff were carrying out joint root cause analysis (RCA) investigations with the clinical director.
- Staff reported there was a reporting system for safety incidents that occurred and that lessons learned were discussed monthly with reports of infection control, wound healing rates, ulcer audits, and cleaning audit being completed. They told us they completed incident forms and received feedback at monthly meetings where incidents were discussed. Staff were aware of incident reporting systems and told us they received feedback on actions taken through staff meetings.

Safeguarding

- The clinical director was the safeguarding lead for the service. We were told they were in contact with the local authority safeguarding team and reported concerns. The safeguarding lead was available to discuss any concerns or issues with staff as needed.
- Vulnerability was considered in all initial assessments and included whether there was a child dependent or a child at risk within the household. This information was held on an internal log.
- Staff in the service made a total of six safeguarding referrals in the year preceding our inspection. We discussed with senior managers how this was reported to commissioning bodies.
- Currently, reports to commissioners only included safeguarding concerns about their own practice, of which there had been none reported. Managers told us the scope of reporting was to broaden so it included concerns staff had reported about external services.
- Staff attended annual mandatory level 2 safeguarding training for both adults and children. The safeguarding lead completed the same level 2 training.
- We discussed safeguarding processes with a nurse. They were aware of how to make a referral to the local authority safeguarding team and who to speak to within the service if they had concerns. We were told there was a form to be completed and also where it was to be sent. Discussion with another staff member took place regarding the process for identifying a safeguarding concern. They gave an example of a referral they had made and why.
- Community staff told us that if there were any safeguarding concerns they would be reported back to line management who contacted the local authority safeguarding team. Meetings were held with the local authority safeguarding team as required. There was a protocol for referrals and staff told us they had a good working relationship with the local safeguarding team. Another member of staff informed us they were fully aware of possible financial abuse of patients and in one case had raised the issue with social services.

Medicines

- No prescriptions were given out by any Accelerate CIC staff. Steroid creams were stored in treatment clinics. In the clinic we observed staff used patients' own ointments or creams if requested by the patient. General one-use ointments or creams were stored in a centrally accessible locked cupboard within the clinical setting.
- We observed staff use patients own ointments or creams in the community. Staff would check patients had the required ointments and would contact the GP if further supplies were needed.

Environment and equipment

- The equipment we saw was clean, modern and well maintained. For example, we observed staff cleaning

equipment between patient appointments in the Tower Hamlets (TH) clinic. Resuscitation equipment was held in treatment centres. It consisted of defibrillator, oxygen and bag valve mask and was checked daily.

- We observed staff advising patients on equipment required to aid wound healing and making relevant referrals to appropriate professionals to obtain equipment.
- In the community, staff would check that patients had the required dressings. Staff carried a small supply of dressings and bandages on community visits to use if patients did not have a personal supply. In the clinics all dressings and bandages were seen to be kept in a centrally accessible locked cupboard.
- Bulky orders were dispatched directly to people's homes. Other items such as bandages, dressing packs, dressings, hosiery were taken out by staff.
- In the treatment centres people were seen in a clean, well lit and safe environment. In Hackney, the treatment centre was located within a hospice, where it rented some rooms. In TH the clinic was located within the hospital grounds where the service's head office was located. We observed this was a well maintained environment that was welcoming to patients. The waiting area was light and welcoming, with adequate seating. Health Information was available on the walls and reading materials available. There were a number of treatment rooms which were also welcoming and maintained patient privacy whilst receiving treatment.
- The service used an outsourced company which was contracted to provide clinical waste services. Monthly audits were carried out by the outsourced company regarding the use and appropriateness of what was disposed of as clinical waste. The audits showed that waste was being disposed of correctly.

Quality of records

- Staff made entries in notes held in people's homes by the community nursing service. Entries were also made in nursing home notes during a nursing home visit. Paper records were used by the service to record their own record of the visit which remained with the nurse. After each new assessment or significant review visit the nurse wrote a letter to the GP to provide them with information and to request any prescriptions required.
- Staff were provided with mobile phones to take photos of wounds and maintain contact with the base. We observed photographs being taken during one visit to monitor patient progress with healing wounds.
- In the clinic we observed staff making entries recorded on an electronic tablet. Templates were available for staff to record information when assessing a patient, which provided prompts for staff. Records were contemporaneous. Staff used the system to generate letters to GPs following assessments. Progress notes were written in a way that was personalised for the patient.

Cleanliness hygiene and infection control

- The TH treatment centre was located within the campus of an NHS trust hospital and cleaning was carried out by the same outsourced company.
- Infection control procedures were observed to be followed with hand washing, hand gel, aprons, gloves and wipes being used to maintain hand hygiene and meet protective personal equipment (PPE) requirements. All equipment used was prepared and disposed of to meet infection prevention and control needs.
- In Hackney, cleaning was carried out by the hospice staff in which the treatment centre was located. Checks were carried out by Accelerate CIC staff on site. We saw evidence that staff washed their hands appropriately between appointments. Equipment was also cleaned between patient appointments.
- In the community we observed infection control requirements being met on the home visits undertaken. Staff carried hand gel, aprons, gloves and wipes when undertaking home visits and maintained infection control procedures in the patient's home and nursing home.
- Cleanliness and infection control audits were carried out in treatment centres and hand hygiene audits also took place. There was an infection control lead and all cleanliness and IPC issues were reported in to the monthly senior leadership team (SLT) meetings. Audit planning documentation showed handwashing audits took place monthly and environmental audits quarterly.
- The senior leadership team (SLT) meeting monitored infection control quality. Minutes for 10 October 2017 identified that hand hygiene audits had showed the service was not meeting its own standard. Training for all staff had been arranged in response.

- A treatment centre environmental report was produced monthly that reported on both hand hygiene and cleaning audit results. The October 2017 report showed what action had been taken since the previous report such as hand hygiene training carried out and what actions had been identified from the current report such as tile repair behind a sink.
- The cleaning and audit report pro forma showed a number of items and areas that were checked each time. They included floors clean, vacuumed and mopped; walls clean, benches, shelves clean, free of dust, areas free of clutter and no offensive odours. Each clinic room and area underwent similar checking. All items were rated as either satisfactory or unsatisfactory. Similarly, the hand hygiene report showed items being checked. They included before touching a patient, before clean/aseptic procedures, after body fluid exposure/risk, after touching a patient and after touching patient surroundings.

Mandatory training

- There were mandatory training days for all staff which meant the service could be assured that training took place. There were two per year; one in November and another in December. Training covered many topics that included fire safety, equality, safeguarding, life support, manual handling and infection control.
- There was a software system for HR that was used by the service to record each member of staff's training. Alerts were sent to line managers informing them of when training was due or out of date. However, the training record was incomplete. The system relied upon staff manually inputting their own records of their training which had not occurred in a number of records although senior staff assured us this had taken place. This had resulted in the training record not being an accurate record of what had taken place.
- Staff reported access to training as required.

Assessing and responding to patient risk

- Risk assessments were carried out for all patients and mitigating actions were recorded within care plans. As a specialist service other agencies contributed to carrying out the care plan tasks and staff told us there were always conversations and dialogue with community services such as community nursing and integrated NHS community service teams in both Tower Hamlets (TH) and City and Hackney (C&H). Escalation of any issues would take place through these contacts that also included GPs, local children's teams and social services. The multidisciplinary team (MDT) clinic prepared letters to GPs following treatment.
- We were given the example of one patient from out of area, who was referred to the MDT clinic within the TH treatment centre and where risks were identified and escalated. The patient was unable to access community team support in their own area and was referred to the service by their GP. Risks to patient health were communicated back to the area where the patient came from and as a result of their interventions the patient was subsequently provided with access to local community team support.
- In the community, staff were observed to undertake a risk assessments when entering patient homes.

Staffing levels and caseloads

- The organisation had grown from seven to 30 employees in the space of six years in line with contractual growth. 60% of the total workforce was nurses while 20% were support staff including administration and directors and 20% were therapy services and medical staff.
- Senior managers told us that recruitment of nurses was a particular challenge for them. We were told that in being a specialist community service, clinical roles were not always easy to fill and as a result they had worked to train and develop their own staff for more senior or specific roles.
  - In C&H they had developed a service in partnership with the local NHS community trust whereby staff from this trust were trained and mentored into delivering a joint lymphoedema service. In information we gathered from the service prior to our visit, we were told that there had been a staff turnover of 21% in the previous year and that current nursing vacancies stood at 11%. The rolling 12 months sickness rate was 2.5%. A workforce report was produced for the monthly senior leadership team (SLT) meeting and a more in depth one for the board was produced quarterly. In the six months prior to our inspection five staff had left the organisation and six staff had joined.
  - The service matched staff grades to the NHS nurse banding structure although not precisely. For instance, band 5 nurses were known as wound care or lymph

nurses, band 6 were specialist wound care or lymph care nurses and band 7s were known as senior specialists and band 8s as leads. The line management structure followed this hierarchy.

- A software package was used as a patient scheduling system. Senior managers told us that staff were expected to see three to six patients per day, which would be allocated depending on their acuity and co-morbidities. Senior staff were able to take less time due to having greater experience and all new patients took two hours for the initial assessment visit. Complex reviews took around an hour and a half. We observed that staff had ample time to complete tasks and deliver high quality care. Staff appeared unhurried, unstressed and were passionate about their roles and in the delivery of care. Emphasis was placed on quality of care and we observed staff taking the time to speak with, properly assess and treat patients.
- Senior managers told us they felt they had the staff to cover current caseloads, but acuity levels were increasing amongst the local patient groups. Senior managers had found that although their role was more advisory they were carrying out more care plan tasks than before due to pressures on community teams such as high vacancy rates and less experienced staff. This had brought up incongruence between what was contracted and what was actually being provided and was to be addressed in commissioning and contractual discussions. In the community staff reported that joint visits with community nursing could be difficult to arrange due to community nursing availability. However, it was observed that written and verbal communication was maintained.
- In terms of covering sickness, as a small organisation it was more complex to pull staff across from different areas to cover absence. In order to rectify this, recent recruitment had more emphasis on versatility across both wound and lymphoedema care. In the clinics staff reported that staff with the required competency would cross cover for clinical and community wound and lymphoedema services as required. The service had recently developed a nurse bank system. There were currently two nurses on this, both former staff. Circumstances meant they were not always available but possessed the right knowledge and experience to fulfil the roles asked of them.

Managing anticipated risks

- We were told that all patients were seen before the start of a busy holiday season, such as Christmas time, to ensure they were reviewed and had appropriate support and care in place during the holiday period. A summer fluctuation in lymphoedema care needs had been identified, where swollen legs and patients taking off bandages due to warm weather occurred. There was also an issue of inappropriate discharges home from hospital and bank holidays causing a knock on effect for patients being seen on a Monday by the community teams.
- Staff had an awareness of what would happen with adverse weather. Staff members said they would follow the business continuity plan.
- Community staff reported that an emergency phone number for staff safety was available and that a risk assessment was undertaken prior to and during patient home visits.

Major incident awareness and training

- There was a business continuity plan in relation to the possibility of terrorist alerts and a recent major incident related to IT issues experienced at the NHS trust they shared a campus with. This was covered in a staff day held in August. Issues included staff travelling in, phone numbers and maintaining IT integrity.
- Staff had an awareness of a business continuity plan. We discussed what would happen with there was a major incident in London. Staff members said they would follow the business continuity plan.

Are community health services for adults effective?

(for example, treatment is effective)

- We found that treatment followed evidence based guidance and best practice.
- Pain management was integrated in to all visits and treatments. Staff were fully aware of nutritional needs around wound care and healing. We observed staff advising patients and carers on hydration and nutritional needs and requirements, and the need for dietitian and speech and language therapy (SALT) input as required.

- There were clear outcomes for both wound and lymphoedema care in line with patient and contractual expectations.
- All staff had appraisals which were linked to objectives and incremental pay uplift.
- Staff competencies were assessed and there were ample opportunities for staff to develop their skills.
- Staff were encouraged and supported to submit journal articles which was seen as a great way of learning and studying a specific topic. Staff were identified for these so they fulfilled a role in the national agenda in wound and lymphoedema care.
- Staff we observed, were clearly specialised and were competent, approachable and knowledgeable about care and treatment.
- There were clear referral processes in place and activity for referral and discharge was tracked in quarterly contract management and board reports.
- As well as there being a team of specialist nurses, there was a multidisciplinary team who practiced from the treatment centres. We observed good working relationships between different professions and there were clear lines of communication with key professional partners such as community nursing and GPs.
- Information was exchanged regularly around care planning. Letters were sent to referrers following assessment and multidisciplinary review.
- We observed staff obtaining consent from patients to treat before undertaking any treatment.

However

- The discharge of patients with long term conditions was an issue for the service as patients came back. Staff encountered issues with referring patients to community nursing and at times kept patients on caseloads for longer as a result.
- Although incorporated in to assessments and covered in training, staff we spoke with understood consent but had limited understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Evidence based care and treatment

- Senior managers told us that practice was linked to a number of best practice guidelines. Best practice in wound infection management followed European Wound Management Association guidance. Structured assessments followed NICE guidance on venous leg ulcers, vascular assessment and pressure ulcer care. European Pressure Ulcer Advisory Panel guidance on prevention assessment and management was followed and also on equipment use.
- The consultant dermatologist who worked at the service for two sessions a week was a national expert on rarer leg ulcer treatment and diagnosis and often called upon to give an opinion in these cases. The organisation's podiatrist was an expert in gait and biomechanics.
- Staff had knowledge of applying evidence based practice (NICE guidance) and were also aware of a lack national guidance in relation to non cancer related lymphoedema. Staff said they kept up to date through clinical meetings.
- In the community staff reported that NICE guidance was followed as required but would be adjusted and/or modified to meet individual patient need and treatment requirements.

Pain relief

- We were told that staff would work with patients to meet their individual pain management needs. Patients and their GPs were advised on any pain management issues.
- We observed that pain was well assessed in both the community and the TH clinic. Patients were asked about pain during visits and in holistic assessments. A pain scale and descriptors were used for patients to identify the nature of the pain, such as 'aching', 'tight' and 'sharp' pains.

Nutrition and hydration

- We observed that staff were fully aware of patients' nutritional needs around wound care and healing. Staff offered simple dietary, healthy eating and exercise advice to patients. For example, we saw a discussion with a patient related to food rich in potassium and which should be avoided due to high blood potassium levels.
- In the community we observed staff advising patients and carers on hydration and nutritional needs and requirements and the need for dietician / SALT input as required. Staff told us they could request dietician referrals by patients' GPs.
- There was a tea and coffee machine in TH treatment centre and a free water dispenser was available.

Community health services for adults

Patient outcomes

- Senior managers told us that a key focus for the lymphoedema service was for patients to receive compression therapy. Key outcomes focussed on cellulitis reduction, admission avoidance, pathway management for early referral and there was a focus on the improving management of lower limb. A 'Timed Up and Go' mobility assessment identified how quickly patients were able to stand up and walk a small distance; this assessment was used within an exercise regime and used as an outcome measure demonstrating improved mobility.
- Within wound care, wound healing times in community and venous ulcer healing rates were key outcomes. The City and Hackney annual contract reports for lymphoedema and dressings demonstrated an analysis of population need and outcomes related to cellulitis and admissions reduction. There was analysis and support. These were provided in a similar way for all contracts. The dressing scheme reports demonstrated improved resource management and control. A similar report showed patient outcomes for a number of different wounds that included venous leg ulcers, moisture lesions, swelling and foot ulcers. It broke down the number of pressure ulcer referrals seen within the required timeframe, source of referrals and ages of patients.
- Details were provided of a review of compression garments, hosiery requirements and a proposal for a new service for which a pilot was being delivered. It showed outcome measurements that had been agreed around standards, treatment and issues of delays to achieving outcomes.
- Other evidence was also provided that outlined outcomes from discrete projects in 2015/16 for TH CCG, and outcomes centred around a needs analysis review and proposal for the lower limb service and redesign.
- In the community we observed a clear approach to monitoring, auditing and benchmarking the quality of services and the outcomes for people receiving care and treatment on a monthly basis.

Competent staff

- In information we gathered from the service prior to our visit, we were told that instead of ad hoc appraisals throughout the year, the board advised that all staff appraisals took place in a defined time period between November and March. They were linked to objectives and incremental pay uplift. Provider documentation showed all staff had received an appraisal prior to May 2017 with the exception being new recruits since this time.
- There was a six month probation review period for new starters. There were eight reviews pending at the time of our visit. Clinical expectations, leadership, team workability and communication were identified as assessed competencies. The service placed high importance on recruiting the right staff and we were told that previous some staff who did not demonstrate the required skills or aptitude had not passed their probationary period and were no longer employed with the organisation.
- There were opportunities for staff to develop their skills which were also assessed through clinical competencies. We were given examples of courses that staff had attended. They included conflict management, manual lymphatic drainage, wound management, pressure ulcer care and debridement. The lymphoedema team required specific updates around manual lymph drainage annually to continue their professional practice.
- Training was being rolled out to some staff to meet the needs of a growing organisation. Root cause analysis (RCA) and leadership training was taking place for some staff.
- Training and education was commissioned by a variety of providers and CCGs outside of their formal contracts such as in Northampton and Lewisham.
- Staff had access to a wide range of learning opportunities such as attendance at conferences and work groups. Staff were supported to submit journal articles which was seen as an effective way of sharing learning and studying a specific topic. Staff were identified for these so they fulfilled a role in the national agenda. We spoke with one member of staff who told us they had been treating a lymphoedema patient who lost significant amounts of weight and so had significant excess skin. The nurse discussed the case with great passion and had written an article on it. They were now supporting the patient to try to obtain individual funding for skin removal surgery.
- Staff told us that good team work meant they frequently received informal support from colleagues. Cases were discussed and advice could be sought from all staff as required. Staff whose practice we observed, were clearly

specialised and were competent, approachable and knowledgeable about care and treatment. Staff told us that regular meetings took place to discuss clinical and operational issues. Staff we met were enthusiastic and passionate about lymphoedema care and clearly enjoyed their roles. Staff reported they had access to continued professional development such as courses and study days for self and service development. Staff reported they were supported to undertake training by use of the appraisal process for development needs. Staff also reported they were supported to undertake research within the workplace.

Multidisciplinary working and coordinated care pathways

- There were specialist nurses in both wound and lymphoedema care and a multidisciplinary team (MDT) that consisted of a 0.4 whole time equivalent consultant dermatologist, a senior podiatrist, two physiotherapists, plus two contracted clinicians from a local provider; a clinical psychologist 0.2 whole time equivalent and a monthly clinic with a Plastic Surgeon. The MDT practiced from the treatment centres where specialist nursing was also present but also visited people in their own homes where the need arose.
- Senior management told us they valued the MDT approach and the influence of each of the professions. As well as there being a team of specialist nurses, there was a multidisciplinary team who practiced from the treatment centres. Sometimes members of the MDT also visited people in the community for reviews of care and risk assessments. A specialist podiatrist was employed 0.6 WTE for gait, biomechanics and mobility review.
- We observed good working relationships between different professions in the treatment centre. Staff spoke to one another with mutual respect across professional boundaries and clearly respected one another's knowledge. We observed good communication between the clinic and GP, letting them know the outcome of the patients' appointment, requesting they prescribe hosiery and any actions required such as giving tetanus injection.
- We observed good handover between nurses and the consultant doctor. A nurse had assessed a patient prior to the consultant reviewing the patient. When the consultant entered the room they were given a succinct and appropriate handover of pertinent information by the nurse. This handover also involved the patient.
- Good MDT working was observed in the community. One staff member commented that the wound care service was "one place for different needs to be met", and that other community based teams worked well with their specialist wound care input. Staff reported a good working relationship with the Tower Hamlets foot treatment team and that the wound care team could access their own podiatrist.
- Staff reported that once they had undertaken an assessment of patient needs and developed a care plan, they contacted GP or community nursing links in the local community healthcare team and shared care until the patient was ready for community nursing input.
- Staff reported joint assessment visits with Tower Hamlets community nurses. Patients may also attend clinic for a wound care team MDT assessment. community nurses led or coordinated the care with the community wound team reviewing patients as requested. Staff reported clear communication with community nursing team within Tower Hamlets for patient needs.
- We observed a joint visit undertaken with a palliative care nurse from the local hospice at which a joint review assessment of a wound was undertaken with the carer also present. Staff reported that wounds were assessed at each visit and that written and verbal communication with the community nurse and GP regarding patient needs and care was made.

Referral, transfer, discharge and transition

- Referrals to the lymphoedema service were through patients' GPs, community nurses and/or hospital teams. Staff reported that referrals were triaged once received for clinic or community assessment visit on receipt through a central referral point. Patients were discharged from the service when clinically appropriate.
- Referrals were triaged and clinical sign off was required by a lead nurse before being accepted. The referral triage process document outlined what information was required to accept and process a referral. It also identified timescales for seeing referrals. These were one to two weeks for urgent lymphoedema patients. 'Urgent' was defined as those with lymphorrhoea, acute cellulitis or palliative care patients. Wound patients with

grade 3 and 4 pressure ulcers were seen within one working day and 10 days for all other referrals. For wound referrals seen in the treatment centre, the target was within one to two weeks for those who had been recently discharged from hospital or who were deemed as urgent after the service's review of the referral. Activity for referral and discharge was tracked in quarterly contract management and board reports.

- Case review and caseload review meetings occurred weekly. Out comes were recorded in patient notes as required. The Lymphoedema database and clinical records tracked discharges.
- Staff reported that referrals were received via a central referral system and usually came from GPs. Patients were often transferred or discharged into the care of the local community nursing service or GP. In terms of when to discharge, senior managers told us that if people were being seen in their own homes, they would discharge when patients were on the way to healing. This was decided through clinical discussion. GPs were able to refer back to the service with sign off for funding.
- The discharge of patients with long term conditions was an issue for the service as patients were referred back to service because they needed further care. Staff encountered issues with referring patients to community nursing and at times kept patients on caseloads for longer as a result. Follow up phone reviews took place for discharged patients within Tower Hamlets.

Access to information

- Senior managers told us they did not have access to the same information systems used by local GPs or the NHS community trusts. Information was however, exchanged regularly around care planning. Letters were sent to referrers following assessment and / or MDT review. We were told the wound care team gave a letter on the day of treatment.
- The service had access to what was reported on the NHS online incident reporting system in Tower Hamlets, which enabled them to see outcomes and learning.
- While observing care, we saw an original referral letter into the service which contained the patient's past medical history and other key information. We also saw some print outs from GP computer systems. We observed staff had access to joint community MDT patient notes in patient's homes and nursing notes within a nursing home.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Training in relation to the Mental Capacity Act and the Deprivation of Liberty Safeguards were completed at the annual statutory management training that all staff attended.
- We observed staff obtaining consent from patients to treat before undertaking any treatment. They checked that the patient was happy for them to examine them or share information with other professionals.
- Staff reported that consent, Mental Capacity Act and Deprivation of Liberty Safeguards issues were assessed within the initial assessment and we saw that patient assessment forms contained a section for identifying and assessing mental capacity. However, staff we spoke with understood consent but had limited understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Are community health services for adults caring?

- We observed staff providing compassionate care throughout our inspection. Patients told us that staff were encouraging, sensitive and supportive. Staff were respectful and took time to listen to the patient, understand their individual needs and respond accordingly. Staff delivered care in an unrushed and holistic manner.
- Patients were clearly involved in decisions about their care. We observed staff explaining care and treatment to patients using appropriate language, the patients' conditions and the physiology behind it. They respected individual choices and offered appropriate treatment choices.
- We spoke with 16 patients and relatives during the inspection and received comment cards from a further 16 patients afterwards. All were positive and complimentary about the service. Patients told us that staff were encouraging, sensitive and supportive.

Compassionate care

- We observed nursing staff delivering compassionate care. Patients told us that staff were encouraging,

sensitive and supportive. Staff were respectful and took time to listen to the patient, understand their individual needs and respond accordingly. Staff delivered care in an unrushed and holistic manner.

- For instance, we observed staff taking the time to promote better health and explain conditions to people.
- We observed compassionate care being delivered by competent staff on home visits and in clinics. One patient described the service at the clinic in TH as excellent "as the staff made the difference". Another patient told us that staff were kind and patient with them.

Understanding and involvement of patients and those close to them

- We observed staff communicating with patients in a manner that they understood. Treatment, care and their condition were clearly explained. Patients were offered treatment options and were able to choose the option that suited their lifestyle and wishes.
- Patients were clearly involved in decisions, which was essential as treatment compliance was vital in lymphoedema care. We observed staff explaining care and treatment to patients using appropriate language, the patients' conditions and the physiology behind it. They respected individual choices and offered appropriate treatment choices.
- Nursing staff offered options for treatment and explained them. There was joint decision making. There were good explanations of treatments consistently offered by staff.
- We observed that communication was maintained within the team and with the patient's wider MDT, including carers and relatives. All patients, carers and relatives were encouraged to be involved in decision making. We observed staff involving families in the treatment and care decision making process. A patient and carer reported that the team gave an 'A' star service, not available elsewhere.

Emotional support

- We observed evidence of staff being aware of patients' emotional needs, identifying when onward referrals were required. Patients were empowered regarding self care and well being. Staff reported the ability to use a psychology service with patients and carers and reported this intervention had had a positive impact for patients and carers. A psychologist was employed by the service one day a week. We were told this had helped coordination and helped to drill down to make sense of the patient.
- A good rapport was seen everywhere with patients. All patients and patient's relatives, ten in all, were positive about the service they received and the outcomes that had been achieved.

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

- The service was working collaboratively with a local NHS trust that provided community health and the local GP care group to review population needs and identify gaps.
- There was multi-agency planning to treat pressure ulcers.
- We observed reasonable adjustments had been made so that disabled people could access and use services. The service understood the cultural needs of its local population.
- Staff understood the needs of their patient group, had a holistic approach to care and advised patients on whole care needs. Difficult to treat wounds were managed with good care planning.
- Contractual key performance indicators for referral to treatment were being met in all but one contract. Where this was the case it had been clearly discussed and documented that the contract required reconfiguring to better meet local needs.
- Complaints were promptly resolved and issues reported but not made in to formal complaints were appropriately recorded and reviewed.

However

- Arrangements were in place to access translation services. We observed an occasion when this was not utilised in the treatment centre, where a patient's relative translated as required. However, staff checked their understanding of the discussion afterwards of what options were available.

Community health services for adults

Planning and delivering services which meet people's needs

- Staff reported an understanding of the needs of the local population by providing personalised care. All grade 3 and 4 ulcers were discussed at the pressure ulcer panel. This was a multi-agency group attended by the service as well as community nursing, local authority community teams and NHS providers of community services. We were told this had high level representation including directors of nursing and the Accelerate CIC clinical director . Cases were presented at the meeting by community nurses and the wound care nurses from Accelerate CIC. We were told that agencies responded to individual incidents reported to this meeting and that work flowed from this meeting.
- Contract review meetings recognised that the population needs were changing and that the original service specification needed updating to meet local these needs. The service worked with CCGs and commissioners to review the activity and demand in the treatment centres. We were told this had led to different ways of working in different areas. Accelerate CIC had also been involved in a number of additional projects and commissioning for quality and innovation initiatives (CQUINs) to enable the provision of new interventions and evaluations. For example there was a borough-wide wound and swelling audit in 2016 and a 'garments made easy scheme' service for GPs.
- The service was working collaboratively with a local NHS trust that provided community health and the local GP care group to review population needs and identify gaps. A joint proposal was being presented to the Alliance Board in January 2018.
- There were patient information leaflets available about lymphoedema and the types of appliances available to treat it. There were also information leaflets about things like suitable footwear. A folder was available in the patients' waiting room that contained published articles on care and treatment that had been written by members of staff. The folder also identified conferences in which the team had been invited to speak.

Equality and diversity

- We observed reasonable adjustments had been made so that disabled people could access and use services. All sites were single storey access. Disabled toilets were located within the clinic and office.
- For bariatric patients we were told that the service had invested in specialist therapy chairs, specialist scales and chairs in the waiting room. In the Treatment Centre there were adjustable therapy chairs, manual handling aids such as a hoist and banana boards.
- There was access to transport with reference to physical capability and if carer attendance was requested.
- Information leaflets were available and could be printed out in large font if required.
- Translation services were regularly accessed through a contracted translation and interpreting service. Senior managers told us this was used for a large cross section of their patients which reflected the multi-cultural nature of Tower Hamlets and people referred into the Accelerate CIC clinics. Flexible appointments were offered to suit people's needs, especially around Friday Prayer time, which reflected the needs of the local population.
- Staff reported arrangements were in place to access translation services. However, we saw in the treatment centre, a patient seen with her daughter as the patient's first language was not English. The patient's daughter translated as required and staff checked afterwards that the patient had understood the discussion and the available options.

Meeting the needs of people in vulnerable circumstances

- We observed a first assessment which was thorough, holistic and specialised. Patient compliance consideration was evident in all visits. Individual needs were considered. Staff looked at aids suitable to the individual such as frames to enable the application of hosiery or sliding sheets also to enable the application of a stocking.
- Difficult to treat wounds were managed within good care planning. Staff told us that over time, healing occurred due to commitment and professionalism. Good relationships were built with patients, who were treated as partners in their care.
- In the community, staff were observed to undertake assessments in people's homes and in care homes. We observed staff make a recommendation to a palliative home care team that a patient be assessed for an electric powered adjustable bed to enable patient independence, support correct manual handling

requirements and staff back care needs. Recommendations were recorded in patient's notes and reported to the appropriate multidisciplinary team member for action.
- It was observed that staff clearly knew their patients and had a holistic approach to care and advised patients on whole care needs. Staff gave patients advice on health and social care needs including advice to a patient about use of a profile bed.
- In the treatment centre, a carer who accompanied a patient reported that the clinic staff were excellent when undertaking wound dressings.

Access to the right care at the right time

- Numbers of patients seen and types of treatments undertaken were recorded. There were target times to see patients from the point of referral. These were all monitored in the performance dashboard. The clinical performance board report was produced from the dashboard and reviewed at board meetings.
- For the year 2016-17, the report to the organisation's board showed there were a total of 360 new referrals to the treatment centres and a total activity of 3378 patient appointments. This was an increase of around one third on the previous year, and was broken down into wound and lymphoedema patients seen by the multidisciplinary team (620 and 375 respectively) and complex wound and lymphoedema patients (1054 and 1170 respectively). Did not attend (DNA) rates were running at 3.7% for the year.
- The average waiting times for appointments at the treatment centres over quarter one and two of 2017-18, was five weeks. This was against a target of six weeks. We were told that wound care referral to treatment targets were ten days for all wounds but 24 hours for all grade 3 or 4 pressure ulcers and the latter was met 100% of the time. For lymphoedema the targets were five days for lymphorrhea and six weeks for all other cases.
- In the community, a total of 2150 patients were seen in TH and 1368 in CH in 2016-17. With lymphoedema cases the target was ten days and was achieved 93% of the time against a target of 90%.
- Over quarter one and two of 2017-18, in TH the target times for seeing wound cases was six weeks which was achieved 80% of the time against a target of 97%. Senior managers told us that that the targets within Tower Hamlets had not been changed since 2008 yet the population needs and nursing capacity had significantly changed. An assessment now took a lot longer and the expectation of completing joint assessments with the community nursing service was also identified as problematic to arrange due to staffing issues in other services. This meant that targets for wound activity could not be met. There was an agreement that the activity focused contract did not reflect the services being provided. This had led to a proposed structure change in partnership with the CCG. The Accelerate CIC board report stated that the contract was 'activity focused and it has been agreed that it is not fit for purpose. Thus targets inappropriate'.
- Managers could access electronic diaries and arrange cover or cancel visits when there was sickness. Staff reported 10 – 14 patients per day in clinic with one to one and 30 minutes per appointment. Staff told us that the community lymphoedema service managed five or six visits daily. Staff reported community nurses provided basic dressings with other dressings supplied by Tower Hamlets dressing service for patients in the community.

Learning from complaints and concerns

- There was a complaints policy and each complaint followed the same process. Each formal complaint was responded to within 10 working days. Complaints were usually resolved at the point of initial response to the complaint.
- There had been four complaints within the year preceding our inspection. Following investigation one was upheld and three partially upheld. They were managed directly by the clinical director and reported quarterly to the board.
- We were told that patients often did not want to formalise complaints and as a service they took informal resolution seriously. Informal complaints were noted on a tracker spreadsheet to which everyone had access. This noted the method of complaint, the issue, actions taken and how it was resolved. If it was not resolved in this way, action taken was recorded such as providing the 'how to make a complaint' leaflet. Data was reviewed at SLT meetings.
- The organisation had a clear and accessible information leaflet which explained how to make a complaint.
- Nursing staff we spoke with were not aware of any complaints.

Community health services for adults

Are community health services for adults well-led?

- There were clear lines of leadership accountability, with the clinical director and chief executive taking a 'hands on' approach.
- The team and management were passionate about the speciality and organisational culture centred on the needs and experience of people who used services.
- There were clear vision and values that had been produced by the whole team and linked to the service's strategy.
- The governance and reporting structure showed clear lines of accountability and clear lines of reporting from the board to clinical leads.
- There were clear audit and improvement processes that were reported to the senior leadership team (SLT) meeting. Monthly SLT meetings were attended by clinical leads and senior managers and monitored a number of risk, quality, operational and leadership items. A senior leadership action log was reviewed at each meeting.
- There were a number of initiatives that directly involved patients and their views.
- The service had expertise in compression therapy and fed into NHS England work streams in wound assessment, management and working with commissioners. Education programmes took place for practice nurses in community NHS trusts looking at baseline skills and champions.

However

- The organisation had grown rapidly in six years. Both the chair and senior managers recognised that a big challenge was being able to maintain their structure, framework and processes while expanding further.
- A staff survey took place in August / September 2017, and was the first anonymous survey the organisation had carried out. Survey results were broadly positive but with elements of learning for the organisation that included better communication, role clarity and expectations, openness, change management and feeling valued. There was a formal feedback meeting from the survey company the week following our visit.

Leadership of the service

- Senior managers told us that Accelerate CIC was a small organisation and the clinical director and chief executive fulfilled a lot of the leadership functions. It was also an expanding organisation and as such responsibilities were now being delegated to other members of staff. For example, incident investigation duties were now being shared and band 7 nurses were undertaking leadership courses.
- Clinical nurse leads were expected to be accountable for staff, and there were leads for different functions within the service. In lymphoedema care the lead was responsible for all lymph care in both TH and C&H. There was a wound care lead who line managed the treatment centre in TH. The clinical director line managed the community wound care team on an interim basis while the post was vacant. Nursing staff were responsible for line management and one to one tasks for the grade below them. Staff described how they could seek support from any staff member should they require it and senior managers told us they always had an open door policy and liked to think staff felt comfortable using this.
- Staff reported that managers including the CEO and clinical director covered nursing duties when the need arose. Staff told us that the CEO and clinical director would accompany nurses on home visits if required. Both were in practice in clinics one day per week.

Culture within the service

- Staff reported that the team and management were passionate about the speciality. Staff reported that the culture centred on the needs and experience of people who used services. We observed this in practice; in the treatment centres and the community. Patients also told us this.
- Staff reported a strong emphasis on promoting the safety and wellbeing of staff, which made them feel respected and valued. Staff reported that there was a culture that encouraged candour, openness and honesty.
- We met with the chair of the board who talked about Accelerate CIC being a growing organisation upon which they wanted to grow good assurance processes. The chair told us it was an evolving organisation, dynamic and always looking at ways of improving. They felt there was a good prevailing attitude in terms of how it looked

at things. Both the chair and senior managers told us one of their challenges going forward, was being able to maintain their strong organisational culture while expanding.

Service vision and strategy

- The operating plan for 2017-18 stated the organisation's vision as 'enabling people to move from a state of illness to wellness…so that those individuals we reach can live their lives free from chronic wounds and in control of the lymphoedema'.
- The values of the service were based on the results of a workshop attended by all staff. We were told that all staff had contributed to the values so there was ownership of them. The organisation's values were identified as Leadership and Discovery, Care and Nurture, Preparedness and resourcefulness, Accountability and Reliability, and Appreciation and Respect.
- Staff told us they felt they had contributed to the vision and that their views were taken in to consideration. Staff were aware of the vision and strategy of the service. Staff in community and clinic services reported they understood the vision and values of the overall service. Staff told us that the patient journey was important and they enjoyed making a difference.
- A strategy day was held in October 2016. There was a planned SLT and board workshop on the organisation's strategy planned for shortly after our visit. A paper developed for board discussion outlined the strategy around revenue growth and productivity efficiency and proposed four strategic objectives. Senior managers told us that as they grew, the challenge was maintaining staff focus on the organisation's core values. In terms of a strategy, values were part of thinking about how staff knew that patients were important, and how this was demonstrated was core to the service.
- Feedback from the 2016 facilitated strategy day that identified challenges, risks and plans for taking forward each function of the business. Minutes showed this was attended by senior leaders, non-executive directors and lead clinicians.

Governance, risk management and quality measurement

- Board meetings were held quarterly. Senior leadership team (SLT) meetings were held monthly and attended by executive directors and senior leads. Board reports were produced for each meeting. They reported on incidents, complaints and compliments, safeguarding alerts, audits, quality improvement and a workforce report.
- Monthly SLT meetings were attended by clinical leads and senior managers and monitored a number of risk, quality, operational and leadership items. A senior leadership action log was reviewed at each meeting. This was a log of ongoing operational and leadership tasks from the meeting and currently covered items such as team risk registers, education schedules, appraisals and audit standards.
- The governance and reporting structure showed clear lines of accountability and lines of reporting from the board to clinical leads for lymphoedema and wound care, community and treatment centres. Clinical review meetings occurred monthly for the whole team to consider clinical issues and quality improvement. We were told the meetings were not documented except in personal actions or specific patient notes/records. The community teams reviewed current caseloads weekly and treatment centre on a daily basis.
- Team meetings were held monthly for both clinical and business areas, and focussed on risk, quality, patient experience and safeguarding. Finance review meetings were held monthly and membership meetings were held quarterly in line with community interest company (CIC) standards.
- Responsibility for leading on audit processes had been delegated and was shared between the clinical director and band 6 and 7 nurses. Audit and improvement was reported to the SLT. An audit plan showed audited items included record management, waste management, HR management and infection control. Improvement was identified within the same documentation. Senior managers told us this was a list of tasks and measurements that the SLT needed to monitor. They included venous ulcer healing, lower leg strategy, antimicrobial usage, wound infection, 'timed up and go' assessment, self-management and sickle cell ulceration. A quality improvement plan for 2017-18 identified quality improvement initiatives for the year ahead and also linked to improvement tasks. They included embedding clinical psychology into the multidisciplinary team structure, developing a lower limb strategy and developing a wound care guideline.

Community health services for adults

- In information we gathered from the service prior to our visit, we found there were two issues documented on the risk register. The first was that recruitment and capacity remained a key issue as there was limited pool of specialist practitioners from which to recruit. The service's response to this identified risk was to develop junior nurses or therapists through mentoring and training programmes. Managers of the service told us this had worked well but the challenge was to maintain the level of staff required to deliver the activity demands of the various contracts. The service also identified the introduction of a new electronic scheduling and patient record system to manage workload. The second risk identified the shortage of experienced community nurses from other community services and how this affected the service's ability to provide advice and expert consultation, as they were reliant on them to implement the suggested actions and care plans. It was stated that this impacted on their workload; appointments took longer and there was a risk posed by the lack of a consistent approach. It was stated that these issues were raised directly with providers and commissioners.
- There were sub-meetings of the board on strategy and development that met annually for review. We met with the chair of the board. They had been chair since July 2017 and in that time had put in to place a vice chair position to take on responsibility if needed. They aimed to get good human resources planning and processes in to place and were looking at the strategy for efficacy and at governance arrangements, strategic direction of the organisation, the operating plan and improvement and quality structure.
- As a community interest company (CIC) it was a requirement to submit an end of year report to Companies House in line with the regulation of CIC companies which was fulfilled.
- Staff reported that quality measurement and governance arrangements were in place and clear to the teams. Staff reported that there were clear lines of accountability including responsibility for cascading information upwards to the senior management team and downwards to the clinicians and other staff on the front line.

Public engagement

- Senior managers told us that patient surveys were reported on in line with contract reporting for both TH and C&H.
- A patient survey report was produced following a survey held at the TH treatment centre for both wound and lymphoedema services. It was held over one week in September 2017, where a total of 40 patients were surveyed. Ten questions were asked that covered staff helpfulness, whether answers to questions were clear, standards of treatment and respect and dignity. Results were overwhelmingly positive with only six of the total 400 questions asked not being rated as the highest. In C&H, 22 patients from the treatment centre were surveyed with 208 out of a possible 220 answers receiving the highest rating.
- Staff reported that feedback from people who used services, and from their carer's, including people who received care at home, was actively obtained. These were regularly discussed at divisional and board meetings and used to inform improvements and learning.
- There had been a 'patient voices' group but it no longer met. We were told that patients were initially enthusiastic but it was a challenge to keep the momentum going. The service had since invested in other patient engagement initiatives including patient experience videos.
- Specific patients had also been part of training of nurses, describing their experience and challenging the way compression therapy is provided. There had also been involvement in a pilot commissioning for quality and innovation (CQUIN) initiative for this year for 'patient activation measures' which had led to the development of a patient diary and also the Breast School teaching sessions.. A photo-shoot had been planned for patients taking part in the national campaign Legs Matter!

Staff engagement

- A staff survey took place in August / September 2017, and was the first anonymous survey the organisation had carried out. 32 questions were asked which ranged from clear leadership and direction, to clearly defined roles and effective communication, to managing workloads and feeling supported. Survey results were broadly positive but with elements of learning for the

organisation. These were better communication, role clarity and expectations, openness, change management and feeling valued. There was a formal feedback meeting from the survey company the week following our visit.

- Staff reported that there was a staff group that had been created to be a staff voice within the organisation with feedback being acted upon on to shape and improve the services and culture. Staff informed us that leaders and staff understood the value of staff raising concerns and appropriate action was taken as a result.
- Senior managers told us that as a small organisation they knew informally what staff were happy and unhappy with. We were also told that away days took place that staff engaged in, particularly when managing change.
- As a community interest company (CIC) the board were accountable to the members. Membership meetings took place that staff engaged in. Membership meetings were held quarterly in line with CIC standards. This aligned with board meetings for members to raise issues to the board via a member's representative.
- Senior leaders of the organisation were considering the introduction of a staff forum. In December a staff workshop was planned to take place on organisation culture.
- Staff told us there were regular meetings where they felt able to offer their views. Staff told us they were involved at different forums. All were invited to the Annual General Meeting, strategic meetings and operational meetings. Emails were used for sharing information. Staff reported they 'had a voice' in service delivery and development.
- Team meetings took place each month. Staff events had included a 'looking back, looking ahead' event and pay award briefing in March 2017. Workshops focused on the development of the operational plan called 'what does good look like?' which took place in May 2017. Recent staff events had included 'bowling for fun!' in June 2017; and a CQC inspection team event in September 2017 where workshops focused on the key lines of inquiry. Membership meetings took place before each board meeting which included summarised board information. A question and answer session for staff took place with the new board chair in August 2017 and an annual accounts presentation and discussion also took place in August 2017.
- Staff received 'ABC' (Accelerate Bite Sized Communication) monthly emails that included team news, staff changes, celebrations, suggested reading, key actions and collaborations.

Innovation, improvement and sustainability

- Staff told us the leadership and staff strived for continuous learning, improvement and innovation by accessing learning opportunities, undertaking research, and use of evidence based practice. Staff informed us that developments to services were assessed and monitored by the use of regular audits.
- Senior leaders told us they had an open door policy but understood that as the service grew they needed to ensure that the framework was there to ensure that things were being done. In 2015 they did some work around giving leads more responsibility to do things themselves. Leaders were looking at what their franchise / replication model may look like and working with what good looks like in relation to this. In terms of a culture we were told it was important to identify people who could assist this growth.
- The chair told us they did a skills piece on what worked well and what could work better, which found that having time to read and consider board papers that were coming out at the last minute would be beneficial. Spending more time on strategy, as opposed to just assurance was also identified. Another piece of work was looking at having the right skills around the board. What experience people had and what they may lose if one member of the board were to leave. They saw stewardship as important, with the NEDs looking at having a balance in terms of being able to meet the needs of the service.
- In terms of innovation, work was being undertaken around developing self management of conditions and personalisation. There was a meeting with the team in December to look at this. The service were experts in compression therapy and had presented on techniques internationally. They also fed in to NHS England work streams in wound assessment, management and working with commissioners. Education programmes around wound and lymph care were taking place. Currently in Lewisham and previously in Essex and Northampton. This was for practice nurses in community NHS trusts looking at baseline skills and champions. It included completing a needs analysis and a wound audit.

Community health services for adults

- Lower limb strategic development was taking place. Around 6 development meetings involving both senior and junior staff took place to look at a new model of delivery. Alongside this, the service was taking part in the development of a national campaign to raise the profile of lower limb issues.

Outstanding practice and areas for improvement

Outstanding practice

- Staff were encouraged and supported to submit clinical and academic journal articles to national publications which was seen as a great way of sharing learning and studying a specific topic. Staff were identified for these so they fulfilled a role in the national agenda in wound and lymphoedema care.
- Staff knew their patient group, had a holistic approach to care and advised patients on whole care needs. Self care was promoted and patients were involved in decisions about their care in an exceptional way. We observed staff explaining care and treatment to patients using appropriate language, the patients' conditions and the physiology behind it. Staff respected individual choices and offered appropriate treatment choices.
- There were a number of initiatives that directly involved patients and their views. The team and management were passionate about their speciality and organisational culture centred on the needs and experience of people who used services.
- The service were experts in compression therapy and fed in to NHS England work streams in wound assessment, management and working with commissioners. Education programmes took place for practice nurses in community NHS trusts looking at baseline skills and champions.

Areas for improvement

Action the provider SHOULD take to improve

- The training record should be an accurate record of what has taken place.
- The provider should ensure that staff have a better understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards.