Care UK Clinical Services Limited

Buckinghamshire Musculoskeletal Integrated Care Service (MuSIC)

Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 4 October 2016 to ask the service the following key questions; Are services safe, effective, caring, responsive and well led?

Our findings were:

Are services safe?

We found that this service was providing safe care in accordance with the relevant regulations.

Are services effective?

We found that this service was providing effective care in accordance with the relevant regulations.

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this service was providing responsive care in accordance with the relevant regulations.

Are services well led?

We found that this service was providing well-led care in accordance with the relevant regulations.

Background

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Buckinghamshire Musculoskeletal Integrated Care Service is part of Care UK Clinical Services Limited. There are two central clinics one at High Wycombe and Aylesbury and six other locations, which were in existing health centres and hospitals across Buckinghamshire. We inspected High Wycombe and Aylesbury as medical clinicians were based at these centres.

Buckinghamshire Musculoskeletal Integrated Care Service was established in 2011. The service provides

Summary of findings

clinical assessments and a treatment service for patients presenting with a musculoskeletal conditions. A musculoskeletal condition is any condition affecting the joints, muscles, ligaments and nerves that may cause pain or reduced function. The service is provided to patients 16 years of age or older.

These treatments include specialised clinics, including hand clinics and a sports injury clinic, as well as group classes focussing on:

- Shoulders
- Pilates
- Osteoarthritis
- General rehabilitation
- Hydrotherapy
- Acupuncture

Aylesbury Vale and Chiltern clinical commissioning groups commission Buckinghamshire Musculoskeletal Integrated Care Service.

The service has been registered since 1st July 2011.

This service is registered with CQC under the Health and Social Care Act 2008 in respect of the provision of advice or treatment by, or under the supervision of, a medical practitioner.

Michelle Saunders is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Our key findings were:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks were appropriately managed and identified.
- Staff were aware of safeguarding and what constituted abuse. Staff at all levels of the organisation understood their responsibilities to protect patients from avoidable harm. They were able to explain the types of concerns which would result in a safeguarding alert being raised and had received safeguarding training to an appropriate level.
- The service had suitable facilities and the environment was well equipped to treat patients and meet their needs.
- The care delivered to patients was evidence-based and in line with key documents such as National Institute of Clinical Effectiveness (NICE) guidance. Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff received training appropriate to their roles and any further training needs had been identified and planned.
- Staff appraisals were completed and staff had sufficient clinical supervision
- There was routine monitoring of patient outcomes of care and treatment, and patient feedback was actively sought on a regular basis.
- There was evidence of multidisciplinary working with other health professionals and organisations outside of the service. Staff worked effectively with the local NHS trust, GPs and specialists; to seek advice when needed.
- When we talked with patients, they said staff were passionate and committed to providing good care.
- Staff were observed providing care to patients with kindness, compassion and dignity.
- The provider had a clear vision, values and strategy, which was shared by all staff. There was an effective clinical governance framework in place. Service leads demonstrated they understood organisational risks and were seen to be positively managing these through action plans and regular reviews.
- There was a clear leadership structure and staff felt supported by management. The service proactively sought feedback from staff and patients, which it acted on.
- Staff spoke positively about the support they were given by senior management.

However,

- Patients and staff told us they found it difficult to make regular follow up appointments.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?
We found that this service was providing safe care in accordance with the relevant regulations.

We found the following areas of good practice:

- There were processes in place for reporting incidents and staff confirmed they received feedback and shared learning. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Systems, processes and standard operating procedures in regard to infection control, medicines management, patient records and the monitoring and maintenance of equipment were reliable and appropriate to keep patients safe.
- Safeguarding was well managed within the service, training was up to date and staff felt confident to report issues when they occurred. The service had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.

Are services effective?
We found that this service was providing effective care in accordance with the relevant regulations.

We found the following areas of good practice:

- Staff used evidence-based; up to date systems to provide care, advice and treatment to patients and there were processes in place to update policies and procedures.
- The provider had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. They were supported to maintain and further develop their professional skills and experience.
- There was evidence of good multidisciplinary working with other health professionals and organisations outside of the service.
- There was a comprehensive induction and mentorship programme for all new staff.
- Clinical audits demonstrated continual improvement in quality of care.

Are services caring?
We found that this service was providing caring services in accordance with the relevant regulations.

We found the following areas of good practice:

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- We saw that staff treated patients with kindness and respect, and maintained patient information confidentiality.
- There was a strong patient-centred culture. Staff were highly motivated and provided individualised and compassionate care. Patients we spoke with told us staff were kind and caring.
- Staff communicated with patients in a way they understood. They took time to identify what was important to the patient and involved them in the planning of the programme.
- Patients gave positive feedback about the caring aspect of the service. They said they had felt listened to, were given clear explanations by staff and had been involved in decisions about their care.

Summary of findings

Are services responsive to people's needs?

We found that this service was providing responsive care in accordance with the relevant regulations.

We found the following areas of good practice:

- The provider was delivering care in partnership with local commissioners. In addition, they were developing innovative, cost effective models of care such as specific exercise classes.
- The provider planned and delivered services in a way that met the needs of the local population. The importance of flexibility and choice was reflected in the service.
- The provider dealt with complaints and concerns promptly and complaints were discussed at all monthly staff meetings. This highlighted any training needs and learning was identified as appropriate.
- The provider had good facilities and was well equipped to treat patients and meet their needs.
- There were initiatives in place to keep “did not attend” and appointment cancellations to a minimum.

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

- The service was commissioned to provide follow up appointments, but the commissioning did not always allow for follow up appointments as regularly as required, the demand for timely regular follow up appointments was not always met.
- Patients said they found it difficult to make an appointment with a named physiotherapist for continuity of care.

Are services well-led?

We found that this service was providing well-led care in accordance with the relevant regulations.

We found the following areas of good practice:

- The provider had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities.
- There was a clear leadership structure and staff felt supported by management. The service had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework, which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- There was an effective clinical governance framework in place. Service leads demonstrated they understood organisational risks and were positively managing these through action plans and regular reviews.
- The provider was transparent, collaborative and open with relevant stakeholders about performance and leaders at every level prioritised high quality compassionate care.
- Staff said managers were available, visible, and approachable. They also said leadership of the service and staff morale was good. Staff spoke positively about the service they provided for patients and specifically emphasised quality and patient experience.
- People, who used the service, and the staff employed there, were engaged in giving feedback about the service. People and staff were listened to, and their suggestions for improvements or changes were taken into account whenever possible.

Buckinghamshire Musculoskeletal Integrated Care Service (MuSIC)

Detailed findings

Background to this inspection

We carried out an announced inspection on 4 October 2016

Our inspection team comprised of an inspection manager, an inspector and two specialist advisors, a physiotherapist and GP, who had extensive experience and knowledge of physiotherapy services.

We informed the Aylesbury Vale and Chiltern CCGs that we were inspecting the provider; and we did not receive any information of concern from them.

During July 2015 and June 2016, the service had received 40,900 new referrals.

Buckinghamshire Musculoskeletal Integrated Care Service is registered to carry out the following legally regulated services/activities:

- Diagnostic and screening procedures.
- Surgical procedures.
- Treatment of disease, disorder or injury.

As part of our inspection, we spoke with 19 members of staff including senior managers, physiotherapists, medical staff, receptionists and support staff. We also spoke with two patients who provided positive feedback about the service. With patient consent, we observed a class of 16 patients. We reviewed policies, procedures, and contracts.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

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

These questions therefore formed the framework for the areas we looked at during the inspection.

We do not currently have a legal duty to rate this service or the regulated activities they provide but we highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

- Staff reported incidents through the providers' electronic reporting system. All staff we spoke with were aware of the electronic incident reporting system and told us they were encouraged to report incidents. Staff told us the system was simple to use and accessible to all.
- The provider reported 24 clinical incidents majority were low harm within the reporting period of November 2015 to September 2016. There were no serious incidents reported within this period.
- Learning from incidents was shared with staff at regular team meetings and we saw evidence of this in minutes of meetings. Staff were also able to give us examples of lessons, which were shared, and action taken to improve safety. For example, practice was changed to count needles before and after acupuncture treatment, procedures after an incident had occurred.
- The service manager and two designated team lead physiotherapists received the medicines and healthcare products regulatory agency (MHRA) alerts and national patient safety notices. They informed staff, followed up and actioned the alerts as needed. Staff told us alerts were discussed at team meetings to ensure all staff were aware of any alerts that were relevant and where action was required.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff could describe the principles of the duty of candour, and gave examples of when this had been put into practice. For example, an email had been forgotten to be sent, to refer a patient for a scan and staff telephoned the patient, apologised and explained why.
- Duty of candour was part of mandatory training, which 97% of staff had completed.

Reliable safety systems and processes (including safeguarding)

- Safeguarding policies and procedures were in place to ensure that staff understood their responsibilities to protect vulnerable adults and children.
- The provider had a local Safeguarding Adults at Risk of Harm Policy June 2016, which included local contacts for domestic abuse support. There was also a corporate Safeguarding Adults Policy August 2015 and Safeguarding Children policy June 2016.
- The appointed dedicated lead in safeguarding vulnerable adults and children were trained to Level 3, they attended corporate safeguarding leads' meetings quarterly. All staff we spoke with knew who the safeguarding lead was.
- There had been no safeguarding alerts or concerns from July 2015 to July 2016.
- There were flow charts in each department detailing the actions to be taken and who to contact in the event of adult safeguarding issues arising. Staff demonstrated an understanding of their safeguarding responsibilities and an understanding of safeguarding procedures.
- Safeguarding training was part of staff mandatory training that consisted of face to face and eLearning. All members of staff had completed adults safeguarding level one and 97% had completed level two. We found 97% of staff had received safeguarding children and young adults level two training and 98% had received child protection training. The target was 90%.
- The majority of staff had received 'prevent' training. Prevent training is the counter-terrorist programme which aimed to stop people being drawn into terrorist-related activity.
- Female Genital Mutilation (FGM) was part of mandatory safeguarding training. FGM is any procedure that injures the female genital organs for non-medical reasons.
- There was a chaperone policy, which was visible in the treatment areas. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.
- There was a system in place to ensure the relevant checks against professional registers, and information from the Disclosure and Barring Service (DBS) were completed. Data provided to us by the provider showed a 100% completion rate of verification of registration for all staff groups working in the departments.

Staffing

- The provider employed 50 staff (37 clinical and 13 administrative), this included six self-employed medical clinicians (GPs).

Are services safe?

- Staffing levels were sufficient to meet patient demand. Processes were in place to provide cover if staffing fell below expected levels. The provider used agency and bank physiotherapists, to cover staff shortages. During April 2016 to June 2016, approximately 40 shifts a month were filled by agency and bank, wherever possible the provider used regular bank and agency staff.
- The provider reported that they had only two whole time total vacancies for qualified physiotherapists as of 30 June 2016. There was an ongoing recruitment programme.
- Physiotherapists told us that they had access to medical clinicians and advice was always obtainable through email.
- Staff sickness rates from April to June 2016 were less than 1%.

Monitoring health & safety and responding to risks

- Patients were triaged prior to consultation and treatment, they were required to complete a comprehensive pre admission questionnaire to assess if there were any health risks, which may compromise their treatment. If staff identified a patient as being at risk, they were referred back to their GP.
- Staff told us that they would liaise closely with the health professional that had made the initial referral into the service in order to share information about known risks or concerns.
- Six monthly emergency scenarios were carried out so staff could respond quickly and be rehearsed should a real life event arrest occur. Feedback was given to individuals on their performance.

Infection control

- There was clear process for the management and prevention of infection. We observed staff adhered to the 'arms bare below the elbow' policy. Arms bare below the elbow means clinical staff were not wearing long sleeves, jewellery on wrists or fingers and no false nails. Staff, washed their hands between patients and used personal protective equipment, such as disposable aprons and gloves.
- We visited two premises being used by the service; all areas were visibly clean and well maintained. We saw there were cleaning schedules in place and cleaning records were kept. Cleaning was organised by the service at High Wycombe and by the local trust at other units. We observed domestic staff with cleaning trolleys and using a colour-coded system to minimise the risk of cross infection.
- Clinical and domestic waste management was in line with guidance on the use of separate colours and receptacles. We observed staff handled contaminated waste correctly.
- Clinical waste was well managed. Each clinic room had a clinical waste bin and a bin for general waste (which we observed were used appropriately). There were containers to store used sharp instruments, such as used needles or scalpels. These were stored appropriately off the floor on shelves or attached to the wall at a reasonable height for safety, and were not overfull. Those we saw had been dated when they were opened in order that items were disposed of in a timely way. An audit undertaken in March 2016 showed 100% compliance in relation to the disposal of waste.
- Hand sanitiser gel was available at the entrances, along corridors, and in all of the clinical rooms and cubicles.
- Treatment areas had disposable curtains to pull around the examination couches. These had all been changed recently, were in good condition, and clean. Staff said they were changed every three months or sooner if they were soiled or damaged. There was paper used on couches, which was disposed of after every patient. There was sufficient single-use clinical equipment such as syringes, gloves and aprons.
- Most staff (97%) had completed their infection prevention practical training. The provider had a target of 90%.
- The provider had an infection prevention control link lead who managed the infection prevention programme. This included training and supporting staff in different departments.
- The lead for infection control had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual update training.
- Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. Hand hygiene audit and training for April 2016 had a 92% compliance level. The provider had a target of 90%.

Are services safe?

Premises and equipment

- The premises we visited were secure, clinical areas were restricted by swipe card system, and CCTV to ensure only authorised people were allowed access.
- There were specific monthly environmental audits undertaken for all clinical areas and these were adapted for the service using the location.
- All patient equipment we looked at had been checked for safety appliance testing, stickers showed when the equipment was next due for service. This included moving and handling equipment such as hoists.
- Single use equipment such as syringes, needles, oxygen masks were readily available and in sufficient quantity.
- Staff could access the equipment they needed and said they had sufficient equipment to care for patients safely.
- The provider maintained water supplies at safe temperatures and there was regular testing and operation of systems to minimise the risk of Legionella bacteria colonisation.
- The units had portable resuscitation equipment. We saw daily check sheets completed to ensure equipment was available and in date. However, at the Brookside clinic in Aylesbury we found an oxygen cylinder that had recently expired. This was raised during the inspection and was confirmed that the cylinder had been replaced the next day.

Safe and effective use of medicines

- The provider had an up to date policy on the management of medications Care UK Health Care Medicines Management Policy 2016.Staff followed the medicine management policy and procedures.
- Medicines were stored safely and securely. Storage was safe in the two locations we visited: Medicines were in locked cabinets either in the treatment rooms, or in a locked clinical room. Senior members of staff held the keys. There was a dedicated room for medication storage and consumables.
- Where required, medicines were stored in medicine refrigerators. Staff were aware of what medicines should be kept at low temperatures, and all those we saw had been stored appropriately in the refrigerators. The temperatures were checked every day when the clinic was open, evidence of this was seen through well-kept records.
- Medicines should be kept at the correct temperature to ensure their efficacy. Staff monitored the clinical rooms daily, we found they were all within the correct limits.
- From the sampling during the inspection, all stock was within the expiry date and stored according to manufacturer's guidelines.
- Staff recorded allergies in patient care records and on individual drug charts.
- The provider carried out six monthly medicines audits, which included stock control, administration and errors. The compliance for June 2016 was 100%.
- Patient Group Directions (PGD) had been adopted by the service to allow physiotherapists to administer medicines in line with legislation. We reviewed these and found that the provider had a Patient Group Directions Policy 2015 which covered the authorisation of staff, documentation and general guidance on best practice required to safely administer.

Records

- All departments used computer-based records and staff had access to these using their own confidential login details. Patient records were kept confidential and secure from people not authorised to see them.
- We looked at two sets of records and found them to be contemporaneous, complete and legible. Records indicated good risk assessments and follow up of any medical concerns or issues identified were well documented and reviewed following appropriate interventions.
- Documentation audits were completed six monthly. The documentation audit completed in September 2016, audited 20 records, which showed compliance of 92% for staff making entries following examination of patients: there was a 100% compliance rate for entries that identified planning and implementation of treatment to patients and actions taken. The overall compliance was 98%, which exceeded the target of 80%.

Mandatory training

- The service provided statutory and mandatory training by eLearning and face-to-face training. The eLearning training could also be accessed from home.
- Mandatory training covered a range of topics including, consent, fire safety, Mental Capacity Act 2005, and

information governance. Face to face, training was available for basic life support and manual handling. However, 87% of staff had completed basic life support, the target was 90%.

- Data provided by the provider for September 2016 showed that compliance with mandatory training was 96%, which exceeded the target of 90%.
- The induction programme for new staff including bank staff covered all the key statutory and mandatory training.
- Team leaders were able to review records to see the training staff had completed and when training, were due for renewal.
- Self-employed medical clinicians were required to complete basic life support training, safeguarding level 3 training and to read corporate policies. The clinical governance lead committee checked assurance of mandatory training. The registered manager told us if doctors were not up to date with mandatory training, and did not provide current and valid practice certificates, they were suspended from practice until the training was renewed and evidenced.

Emergency awareness and training

- All staff we spoke with had training on fire evacuation plans and stated fire equipment was checked yearly. We saw fire appliances and fire blankets had been recently serviced.
- There was a corporate business and continuity plan centred on individual incident plans such as fire or loss of utilities.
- There was a business continuity plan in the case of prolonged loss of premises due to disaster or loss of staff in case of disease outbreak. Managers told us they would divert patients to another unit if the need arose.

Are services effective?

(for example, treatment is effective)

Our findings

Assessment and treatment

- Staff provided care to patients, which took account of national guidance, such as National Institute for Clinical Excellence (NICE) best practice guidelines. For example, staff assessed the risk of fragility fracture in osteoporosis patients. Osteoporosis is a medical condition in which the bones become brittle and fragile from loss of tissue, typically because of hormonal changes, or deficiency of calcium or vitamin D. This was in line with NICE clinical guideline 146.
- Osteoarthritis patients were treated using the Osteoarthritis care and management: NICE clinical guideline 177.
- Patients with rheumatoid arthritis were provided care based on Rheumatoid Arthritis in adults: NICE clinical guideline 79.
- Adherence to policies and national guidelines was discussed at management and departmental meetings to ensure care and treatment offered was up to date.
- Policies and guidelines were developed in line with the current national guidelines and were easily accessible via the corporate intranet site. We saw evidence of staff adhering to guidelines. Staff were expected to sign the policy and procedure sheet when they had read them.
- The provider also used evidence based clinical guidelines from the Chartered Society of Physiotherapy. For example, guidelines on treating a frozen shoulder.
- There was an on-going audit programme to evaluate care and review clinical practice. These included audits, such as a secondary care audit, which audits the appropriateness of referral to secondary care by a clinician.
- Standard operating procedures (SOPs) were in use across all locations, which was accessible to new, agency and locum staff. Updates to policies were on the corporate intranet and staff signed to acknowledge they had read the updates.

Staff training and experience

- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- The provider had a 12-week induction programme for all newly appointed staff. This covered topics such as safeguarding, infection prevention and control, fire safety, equipment handling and confidentiality.
- All new staff underwent a corporate induction which included a departmental orientation programme. As part of this process, staff were allocated a mentor who was a senior member of staff.
- Staff confirmed that appraisals took place and staff told us they had received an annual appraisal. Records showed 100% of staff had had an appraisal in 2016, including administrative and clerical staff. We heard that staff thought the appraisal system was effective as it formalised individual competencies and identified training needs for the next year.
- There was regular bi monthly in house training this was protected time and included internal and external speakers. It included a range of topics such as pain, appropriate referrals to injection clinics, case studies to hip assessment and imagery review.
- Staff had protected time for weekly continuous professional development sessions.
- The local medical director was responsible for carrying out clinical supervision medical clinicians. We saw evidence of medical appraisals and clinical supervision to support this.
- A new training programme had been developed for less experienced physiotherapists to be supported in extended roles.
- The provider had a competency assessment framework for physiotherapists to complete before they could perform an injection into joints and soft tissue structures.
- Musculoskeletal physiotherapists are health professionals with advanced postgraduate training in the assessment and diagnosis of musculoskeletal conditions. The provider had a competency log for staff to undertake the role of a musculoskeletal physiotherapist.
- Staff told us that they were actively encouraged to undertake training additional to their mandatory requirements and were supported to improve their knowledge if they identified areas for improvement.

Patient outcomes

- The provider routinely monitored patient's outcomes and the findings were reviewed on a monthly basis in a variety of meetings.
- The latest intra articular injection audit demonstrated 73% of patients did not return to the provider because it had been successful and 5.3% of patients were referred onto the local NHS trust after a failed injection.

Are services effective?

(for example, treatment is effective)

- The provider reported that in their most recent osteoarthritis knee class: 37% of patients reported a 70% improvement, 21% patients reported some improvement, 42% of patients reported no change, but of those 65% reported their activities of daily living had improved: None reported their symptoms were worse.
- The provider monitored patient outcomes from an Activities Daily Living (ADL) audit. From April to June 2016: 91% of patients reported an improvement in their health. The providers target was 85%.
- Staff had protected time to discuss complex patients and junior staff were asked to discuss patients they had seen who were not improving by the third appointment.
- The provider held monthly meetings, during which 5% of patient records were randomly selected to discuss the care and treatment the patient had received.

Multi-disciplinary working and coordinated care pathways

- Medical staff, physiotherapists, patient management centre and administrative staff worked collaboratively and our review of records confirmed there were effective multidisciplinary (MDT) working practices. For example, we saw physiotherapists followed therapy guidelines documented by doctors.
- There were service level agreements with the local NHS trust in the event a patient required further treatment. The service manager told us this this worked well and there was effective joint working.
- There were good links with local GPs and staff were able to request diagnostic appointments for patients when it was deemed appropriate. The units had good working relationships with the GP practices, which recognised and respected the skills of the physiotherapists at the units.
- Discharge summaries were emailed to GPs when patients were discharged from the service. Care and discharge summaries were also given to patients on discharge.
- There were good working relationships and access to diagnostics such as X-ray service in both central clinics, provided by Care UK at High Wycombe and by the local NHS trust at Aylesbury.
- The clinical lead and local medical director managed a dedicated musculoskeletal opinion email through which staff could request advice and clinical support.

Pain relief

- Patients told us that they were given advice regarding pain relief and whom to contact should they require further advice and support.
- Staff referred patients to the local chronic patient management service if they felt it was needed.
- The provider recently employed a medical clinician who was a pain specialist, they worked with the local NHS pain service which meant patients could be seen quickly without need for a further referral; the clinician could then share his expertise within the service.
- Patients were referred to an online pain programme, if it was assessed as appropriate for the individual.

Consent to care and treatment

- There was a corporate Consent for Physical Examination and Treatment Policy (2016) which all staff could access through the intranet.
- Staff knew about the importance of obtaining valid consent from patients or an appropriate adult. The patient record system did not require staff to document that they had asked for, and been given permission to, carry out examinations or provide treatment to patients. Written consent was gained for injections and acupuncture. However, staff knew the protocol for care and treatment provided by departments meant verbal or implied consent was satisfactory, and written consent was not required.
- Staff told us that they had received training in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguard (DoLS), at the time of inspection there was 97% compliance.
- Staff told us they very rarely saw patients who may lack capacity to make an informed decision about their care and treatment. We spoke with staff about informed consent and they were clear about the procedures to follow for patients who lacked capacity.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

- The provider took part in the friends and family test (FFT) to gauge feedback from patients about the quality of service and whether patients would recommend the service if they needed similar care or treatment to their friends and family required treatment. For the reporting period for August 2016, it was reported 96% of patients would recommend the service. The response rate was 6%.
- During our inspection, we observed staff showed compassion and care and treated patients with dignity and respect. Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard to maintain patient information confidentiality.
- We observed curtains used in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Staff made sure patients were comfortable with being treated by members of the opposite gender and same sex clinicians were identified and offered where appropriate. Staff told us they would make sure all patients were comfortable with the person who was treating them.
- Patients could request a chaperone to be present during consultations and treatments and there were signs clearly on display to inform patients that this was available.
- We spoke with two patients. Both were very positive about the care they had received. Their comments included "efficient joined up care" and "from the call centre I received good information and advice over phone: it was practical and informative."

Involvement in decisions about care and treatment

- Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- Staff provided clear information to patients about their care and treatment and informed them of any delays.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

- The provider was commissioned to provide musculoskeletal services for local people and worked with two local Clinical Commissioning Group (CCG) in planning services for NHS patients.
- Patients had to be registered with a Buckinghamshire GP and be referred by the GP, consultant or other health care professional.
- The unit at High Wycombe consisted of two waiting areas, consultation rooms, clinical room, gymnasium and a single point of access room (call centre) where appointments were made. The Aylesbury unit was within a local health centre, there was a waiting area, clinical rooms and treatment areas.
- All appointments for Buckinghamshire Musculoskeletal Integrated Care Service (MuSIC) were booked through the single point of access centre. This was also an information service. The central booking service was accessed through a single telephone number for all appointments.
- This single point of access, which was called the patient management centre, was based at High Wycombe, and received all referrals, made all the bookings and managed all the administration associated with a patient pathway.
- Patients were able to choose from eight locations for treatment; depending on the type of treatment required and the location that was most convenient to them. The medical clinicians were based at High Wycombe and Aylesbury.
- Agreements were in place with the local NHS trust to provide further treatment and support if required.
- The service was planned to coordinate with the X-ray facilities at High Wycombe and Aylesbury. The X-ray facilities were open the same hours at both sites, patients were able to come back to the unit at the next opportunity, or were referred to another service if the situation was more urgent.
- The provider had developed classes based in response to patient need, for example, back pain classes became general exercise classes.

Tackling inequity and promoting equality

- Staff recognised the need for supporting people with complex or additional needs and made adjustments whenever possible. Information was provided on the service website about support for patients with additional needs and new patients were asked to contact the service prior to their appointment, if they needed any extra help.
- Staff were made aware of patients in vulnerable circumstances through the referral process from GPs.
- Staff told us that although they rarely treated patients with a learning disability they were able to make reasonable adjustments such as ensuring they were accompanied by a friend or carer who could stay with them during their consultation and or treatment.
- For patients' with visual or hearing loss signage was available and a hearing loop was provided in the main reception of the department. For patients who were hard of hearing, an interpreter would be organised. Visual physiotherapy communication tools were available through a computer programme that consisted of pictures and different languages.
- There was bariatric equipment available, for example large weight bearing plinths and other specialist equipment to support patients. Bariatric patients are those with excessive body weight that is dangerous to health.
- Staff told us that translation services were available for patients who did not have English as a first language. Patients were also told about multi-lingual staff that might be able to help them. However, we did not see notices informing patients that this service was available.
- The layout of the departments we visited facilitated easy access to all areas for people in a wheelchair or with limited mobility.
- We reviewed the minutes of the Equality and Diversity Action Plan Meeting held in July 2016, which looked at individual people's health needs and how patients were being assessed and how this could be improved.
- The patient guide leaflet was available to be ordered through the service intranet website in other languages and in Braille, audio or large print. However, we did not see any leaflets on site, other than in English.

Access to the service

- The provider was open between 8am and 7pm Monday to Thursday and 8am to 5pm Friday and Saturday.
- We observed and spoke with staff at the call centre, who were responsible for booking patient appointments. The manager monitored the number of abandoned calls,

Are services responsive to people's needs?

(for example, to feedback?)

total calls and longest time a caller had been waiting. The provider had an internal set target of answering calls within two minutes, we were told the aim was to get below 10% of calls abandoned, in September 2016 15% of calls were abandoned (total calls received 9596 and total calls answered 8200). The service were recruiting more call handling staff to address the 25% abandoned calls.

- The provider monitored waiting times across all the sites and the booking team offered patients alternative sites, which had the lowest waiting times.
- Patients told us that the availability of new appointments was good and appointments were provided at times that met their needs. Patients were complimentary about the efficiency of the service as a whole.
- The provider monitored the average number of days patients waited from initial contact to consultation and from initial assessment to onset of treatment. Data submitted by the provider in September 2016 showed a range of 10-50 days, with an average wait time of 31 days for physiotherapy.
- The provider monitored cancellation rates for appointments, between January and June 2016, they ranged from 4.4% to 9% a month. This was generally due to the clinician becoming unavailable at short notice. Patients were offered another appointment in a timely way if their appointment was cancelled.
- Physiotherapy staff and patients raised concerns around the waiting time for follow up appointments. Follow-ups were booked by the Patient Management Centre (PMC) or individually by the clinician with the patient. Wait times varied depending on the clinician, from a few days to four weeks. Patients said they found it difficult to make an appointment with a named physiotherapist for continuity of care. The service was commissioned to provide follow up appointments, but the commissioning did not always allow for follow up appointments as regularly as required, however, the provider was in discussion with the CCGs for this to be included.
- Information boards identified who was in charge and of any delays to the clinics, which were running, these were seen at both units we visited. Reception staff told us they would inform patients when they arrived, how long the wait would be and advised patients of delays.
- The 'did not attend' (DNA) rate between June and August 2015 ranged from 6% to 7%. Text message reminders were sent to patients to help minimise DNA rates, which also gave patients the option to cancel appointments.

Concerns & complaints

- The provider had an up to date complaints policy with a clear process to investigate, report and learn from a complaint. There had been 52 written patient complaints and 22 written accolades for the last 12 months. We saw from minutes of meetings that complaints were discussed.
- The service manager monitored all complaints and responded to them in-line with the corporate policy. There was an expectation complaints would be acknowledged within 48 hours and a written response to the patient within 20 working days. Complaints were investigated by the team leads with involvement from medical staff and physiotherapists if needed.
- Learning and action from complaints were documented at service and corporate level. Themes of complaints in the last 12 months included: patient expectations, therapist and patient communication. However, the most common concern raised by patients was the understanding of Individual Funding Request (IFR) policies and procedures, this was being addressed by the provider through discussion with commissioners.
- Complaints, concerns and compliments were also managed through the patient advice and liaison service (PALS) at the local NHS trust. There had been five patient complaints managed fully through the PALS route within the last year.
- Lessons were learned from concerns and complaints and action was taken as a result to improve the quality of care. We found the learning points from each complaint had been recorded and communicated to the teams or appropriate action taken. For example, a patient complained about physiotherapist's attitude. The action taken by the provider was to implement motivational interview training.
- There were posters and leaflets on display in the waiting areas advising patients how to raise concerns and give feedback. The information clearly stated how feedback could be given and how concerns would be dealt with.
- All of the patients we spoke with told us they had no complaints about the care and treatment they had received from the service.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Our findings

Leadership, openness and transparency

- The provider was led by the service manager, deputy service manager, clinical lead and local medical director. All the heads of department reported to one of these persons.
- There was a clear leadership structure in place and staff felt supported by management. All staff told us the senior management team were highly visible. Staff described knowing them on first name terms and were encouraged in conversation and feedback.
- The Fit and Proper Person Requirement (FPPR) places a requirement on providers to ensure directors and board members are fit and proper to carry out these roles. The organisation had a recruitment and selection policy, which contained the criteria and processes for checking whether current and newly recruited board members were fit for their role. The Fit and Proper Persons Requirement for Directors Policy June 2015 outlined the requirement to ensure that all persons appointed as directors of Care UK satisfy the fit and proper person's requirement.
- We observed staff demonstrated mutual respect. There was effective teamwork and professionalism in the way the organisation was managed.
- Medical staff spoke positively about the leadership and senior members of the service and described good working relationships.
- All staff we spoke with were positive about working for the service, they felt listened to and valued. They said patients and staff knew if they raised an issue, it would be taken seriously.
- Staff told us they had been supported to undertake the team leader development programme.

Vision and strategy for this this core service

- All staff we spoke with were aware of the corporate wide values and was able to describe them to us which included being: every one of us make a difference, customers are at the heart of everything we do and together we make things better". There was a corporate mission, which was "fulfilling lives".
- Staff demonstrated the providers' values and behaviours in the care they delivered. All staff we spoke with were passionate about the service they provided and believed they consistently put the patient first.
- The registered manager was knowledgeable about the local corporate strategy and understood how this affected local provision of services. They also had a good understanding of the commercial aspect of the service, in order to facilitate continued engagement and securing a contract from the CCGs.

Governance arrangements

- There was a clear governance and reporting structure in place with an infection prevention and control lead, clinical governance and audit lead, safeguarding and prevent lead, and health and safety lead in post: They formed the quality governance and assurance committee which reported to the clinical lead, service manager and local medical director.
- The quality governance and assurance committee met bimonthly to discuss a range of governance issues across the service, the minutes showed evidence that discussion on findings from audits, incidents and complaints took place. We saw evidence of action points proposed and improvement plans from agreed outcomes and decisions reached. This was then shared at the team leaders meetings.
- Team leads met bimonthly, minutes showed they discussed staffing issues, complaints and updates from the clinical lead. There were action plans proposed and clear lines of responsibilities identified.
- Team meetings were held at each location, records demonstrated a variety of topics was discussed for example, clinical governance, waiting lists, complaints and clinical updates. These meetings were used for the passing of two-way information.
- The local medical director had a responsibility for maintaining safe practising standards amongst the medical clinicians. Each medical clinician was required to complete an annual appraisal and clinical supervision with the local medical director, during which data on their clinical performance was discussed. The provider also ensured that clinicians had up to date revalidation dates and GMC registration of GPs.
- The provider had a risk register, which contained five risks. We saw risks categorised as; person related, information governance, financial and business delivery risks. The risk register showed nature and level of risk, control measures required and name of person responsible for control of the risk. Staff were aware of and had understanding of the risks.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

- Senior management demonstrated they had a clear understanding of the external risks to their organisation.
- The provider had 21 key performance indicators held on a quality and performance dashboard, which was an improvement tool for measuring, checking, and analysing clinical standards. The dashboard included medicines management, percentage of patients receiving treatment and number of patients referred to secondary care at triage stage. This was discussed at leads and team meetings.
- There was a programme of continuous clinical and internal audit in order to monitor quality and to make improvements. For example, we saw a clinical audit used to monitor competence in effectiveness for procedures such as joint injections, based on data from all injecting clinicians.

Provider seeks and acts on feedback from its patients, the public and staff

- The provider encouraged and valued feedback from patients and the public. It proactively sought patients' feedback and engaged patients in the delivery of the service.
- Patient feedback was gathered through patient open forum evenings, these identified areas where improvements could be made.For example, the wording on patients appointment letters was changed after patients raised it as an issue.
- Drop in forums during clinic hours, were organised when the evening sessions appeared not to capture many patients.
- Feedback was also gathered from written patient questionnaires. These included short open and closed questions regarding facilities and treatment.
- The provider introduced back pain classes, general exercise classes, knee classes and Pilates, in response to patient feedback.
- Discussions and feedback from GPs had improved the service. For example, GPs had requested diagnostic results be embedded in discharge letters and the use of acronyms reduced.
- Staff could be nominated by other staff members for acknowledgement of their hard work through the Care UK Healthcare Heroes recognition scheme.
- The staff survey, 'Over to you' engagement scores for 2016 were 66% with a response rate of 63%. Thirty-eight of 48 staff responded. One of the top highest scoring questions were "I know how to raise a concern at work", which was 97%.
- Staff told us they were encouraged to be involved in developing new pathways for patients.