Battersea Healthcare Community Interest Company

1-1-614995621

Community health services for adults

Quality Report

Battersea Healthcare CIC
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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-686251264	Head Office		SW11 6HN

This report describes our judgement of the quality of care provided within this core service by Battersea Healthcare Community Interest Company. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Battersea Healthcare Community Interest Company and these are brought together to inform our overall judgement of Battersea Healthcare Community Interest Company

Summary of findings

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Summary of findings

Overall summary

There are no ratings for this inspection as we do not currently rate small community based independent health services.

- There were systems for identifying, investigating and learning from incidents relating to the safety of patients and staff members.
- The service had clearly defined and embedded systems, processes and practices in place to safeguard patients from abuse.
- The staffing levels were appropriate for the provision of services offered with a good staff skill mix across the service.
- Risk management processes were in place to manage and prevent harm.
- Patient outcomes were reviewed as part of audits or quality improvement.
- Staff had the relevant skills, knowledge and experience to deliver the care and treatment offered by the clinic.
- The clinic shared relevant information with other services appropriately and in a timely way.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Staff treated patients with dignity and respect.
- Patients were involved in decisions about their care and treatment.
- The service offered flexible appointments to meet the needs of their patients.
- There was a system in place which ensured a clear response to complaints with learning disseminated to staff about the event.
- The clinic had a governance framework that supported the delivery of quality care.
- There was a clear leadership structure; however there was no robust scheme of delegation within the service.
- The service encouraged and valued feedback from patients, the public and staff.

However;

- There was no dedicated clinician input to medicines management. Medicines used at the clinic were being managed by a person who was not a clinician. However after the inspection, we were told by the provider, that Medical Director and Clinical Lead had input into medicines management.
- The provider did not have appropriate medicine storage facilities. Medicines were stored in a plastic storage container.
- The consulting rooms where patients are examined, but which do not have a height adjustable examination table.
- Patients were not given copy of the consent form.
- There was no information available in the clinics informing patients on how to make complaints. The complaint process was not available to patients.

Summary of findings

Background to the service

Battersea Healthcare Community Interest Company is a GP - owned community interest company and social enterprise set up to provide quality healthcare for the people of Wandsworth. The services provided are a Musculoskeletal Interface Clinical Assessment Service (MICAS) and dermatology outpatient services. These were provided through a network of partner organisations that make those services available across Wandsworth

The services they provide are commissioned by Wandsworth Clinical Commissioning Group, and so are available to all patients registered with GP practices in Wandsworth.

The Musculoskeletal Interface Community Assessment Service (MICAS) provides registered patients in Wandsworth with assessment and treatment of bone and joint conditions and the dermatology service caters for a range of dermatological conditions.

MICAS engage a mix of clinical skills including GPs with Specialist Interest (GPSI) in musculoskeletal problems (A GPSI supplements their role as a generalist by providing an additional service while still working in the community). They also engaged Sports & Exercise Medicine Consultants, and Extended Scope Physiotherapists (ESP). The ESP's are specialist physiotherapists or who work in an extended role alongside a Medical Consultant). The Dermatology Service engaged the services of GPSIs, and Dermatology Consultants from acute hospitals. Approximately 2,800 new patients and 1,000 follow-up patients were seen in 2015 by MICAS, whereas the dermatology outpatients' services saw 1,300 new patients and 750 follow-up patients. Children and young people over the age of three accounted for about 8% of the dermatology services provided.

All referrals are received and managed by a central hub located in Battersea. The hub is open from Monday to Friday 8.30am until 5pm and book patients into the appropriate service following clinical triage. The provider offers services from four locations in Wandsworth offering patients a choice of location and times to suit their lifestyle. We inspected the main head office as well as two GP practices where dermatology services were provided.

Jeremy Fenwick 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.

As part of our inspection, we asked for CQC comment cards to be completed by patients prior to our inspection. We received 21 comment cards which were positive about the standard of care received. We spoke with six people on the day of inspection and telephoned 16 people who also provided positive feedback about the service.

Our inspection team

Team Leader: Roger James

The inspection team included two CQC inspectors and a variety of specialists: community safeguarding lead, and a community physiotherapist.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

'Before visiting, we reviewed a range of information we held about the core service and asked other organisations to share what they knew. We carried out an announced visit on 14 – 15 November 2016. During the visit we spoke with staff and service users. We observed how people were being cared for and reviewed care or treatment records of people who use services.

We reviewed policies, procedures and other documentation in place. We did not carry out an unannounced visit.

What people who use the provider say

All patients and carers we spoke with were consistently positive about the care they received. We spoke with three service users who attended the weekly clinic during our inspection. All made positive comments about their experiences of the care and support provided.

We provided the organisation with comment cards for people to complete and share their views of the service with us. The completed cards all contained positive feedback with specific comments including "I've never experienced anything other than excellent care in the times I have used the service. I am always treated with dignity and respect", "the staff are thoughtful and caring at all times. "I was treated with respect at all times, made to feel welcome and offered a drink while I waited".

Areas for improvement

Action the provider MUST or SHOULD take to improve

There were areas where the provider could make improvements and must:

- Ensure there is dedicated clinician input to medicines management. Medicines used at the clinic were being managed by a person who was not a clinician.
- Introduce a medicines management policy and ensure access to medicines is restricted to authorised staff only.

There were areas where the provider could make improvements and should

- Review the suitability of using consulting rooms where patients are examined, but which do not have a height adjustable examination table.
- Ensure that staff document whether patients are given a copy of the consent form.
- Review the information available at the clinics being held in GP surgeries so that patients would know how to complain specifically about the services provide by Battersea CIC.
- Review the processes for reporting and logging incidents within dermatology to ensure that learning is shared and re-occurrence is avoided.
- Review the complaints process so that there is clear communication to patients about how to complain about the service.

Battersea Healthcare Community Interest Company

Community health services for adults

Detailed findings from this inspection

Are services safe?

By safe, we mean that people are protected from abuse

Summary

Battersea Healthcare Community Interest Company had systems and practices in place to ensure people who used the service and staff were safe including:

- The service had systems for identifying, investigating and learning from incidents relating to the safety of patients and staff members.
- The service had clearly defined and embedded systems, processes and practices to safeguard patients from abuse or the risk of abuse.
- The staffing levels were appropriate for the provision of care and treatment offered by the service with a good staff skill mix across the service.
- There were risk management processes available to manage and prevent harm to patients.
- The service had an infection control policy and procedures to reduce the risk and spread of infection.

However;

- There was no robust medicines management policy and procedure.
- The provider did not have appropriate medicine storage facilities.

Detailed findings

Incident reporting, learning and improvement Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- The provider had robust systems to report and learns from incidents and reduces the risk of avoidable harm to patients. Staff told us that the culture was one of honest reporting and a positive move towards change. Staff told us that the incident reporting procedures allowed staff at all levels and across multidisciplinary teams to reflect on practice.
- We were told by the management that incidents were discussed by the senior management team at their weekly meetings. Further discussion took place at monthly clinical governance meetings.

Are services safe?

- Staff we spoke with were able to describe the reporting procedure for all incidents. If a patient was involved in an incident they were informed of what had happened and given an apology. Staff informed the head of department and completed an incident reporting form.
- Staff told us they would inform the service manager of any incidents and there was also an incident recording form available for staff to complete and document any incidents/accidents.
- We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared with staff to make sure action was taken to improve safety in the practice.
- Staff knew when to apply duty of candour. Staff we spoke with were aware of the duty of candour and could demonstrate their individual responsibility to be open and honest with patients and families when something went wrong. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This Regulation requires providers to be open and transparent when things go wrong in relation to the care of patients, compelling them to act in an open and transparent way. The Regulation also requires the provider to inform patients and relatives of incidents which had involved them.
- The service carried out a thorough analysis of significant events. When there were unintended or unexpected safety incidents, people received reasonable support, truthful information, a verbal and written apology and were told about any actions that were taken to improve processes to prevent the same thing happening again. They kept written records of verbal interactions as well as written correspondence.
- All the staff we spoke with, including reception staff, were aware of the significant event policy and knew how to escalate any incidents. They were aware of the forms they were required to complete and knew who to report any incidents to at the practice.

Dermatology services for adults, children and young people

- The service did not report any incidents in 2015/16. Doctors we spoke with said that they would raise issues by email or telephone with the clinical lead. However, these issues were not always considered to be incidents and therefore may not have been logged. This reduced the opportunity for learning across the service to prevent a recurrence.
- There were examples given of where practices had changed as a result of learning from incidents. An example was the process of checking liquid nitrogen at a surgery, following a time when a procedure had to be cancelled due to lack of availability.

Duty of Candour

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- 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 service users (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Information had been provided to staff through email and on the intranet regarding the duty of candour. This also included guidance on the action they were required to take in order to meet the appropriate regulation.
- There had been no formal training for staff regarding the duty of candour. The registered manager had become aware of a lack of understanding of the regulation and had reissued guidelines to all staff. The registered manager discussed these with the staff. During these discussions the registered manager assessed the staff members understanding of the duty of candour principles. Staff were then all required to provide a signature to evidence they had read and understood the regulation.
- The registered manager planned to create a log to record and evidence the action taken following any Duty of Candour incident. This had not yet happened as there had been no reported complaints or incidents which came into this legislation.

Safeguarding

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- The provider had systems, processes and practices to keep patients safe and safeguarded them from abuse. A GP was the lead for safeguarding and had received child safeguarding training to level three. The GP we spoke

with could not recall any recent safeguarding referrals. Staff were aware of the systems and how to report concerns. The organisation's policy was accessible to all staff via their intranet and staff knew where they could find this.

- Staff we spoke with were clear of their responsibilities following identification of any safeguarding issues. Staff we spoke with were knowledgeable about when they would refer people to external organisations. For example, following disclosure of abuse or assault.
- Clinical staff had completed safeguarding children level 2 and 3 raining which enabled them to recognise any potential safeguarding issues should children or adults attended the clinic. All staff were provided with the contact details for the safeguarding teams should they observe any concerns.
- The staff members gave us examples of situations where they would raise safeguarding concerns and knew the procedure to follow.

Dermatology services for adults, children and young people

- The service used the 'E-MIS' system for electronic records. Referral letters received from the GP were scanned and attached to the patient record. These referrals included a summary of the patient's pre-existing medical conditions and a current list of medication. If the clinician required further information about the patient's previous medical history, they could, after gaining consent from the patient, access the full GP record on the system. All records of consultations were sent back to the GP within two days, so that the main patient GP record was updated by their GP.
- All doctors within the dermatology service were trained in adult safeguarding and also to child safeguarding to level three. This was an enhanced level of training suitable for those working with children and young people. Training for doctors was completed at the surgeries that they were based or by the agency that they were employed from, rather than the provider.
- There had been no safeguarding alerts raised by the staff working at the provider. There was a clear policy showing the process for referrals to be made. Clinician's were alerted by the 'E-MIS' record system if there were any child protection issues,scuch as if the child was subject to a child protection plan.

Medicines

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- Medicines were stored in the plastic container in the general office under the supervision of the service manager. They were not stored in a secured lockable cupboard.
- Medicines were stored in a plastic container and were accessible only by the service manager who managed the process of checking the medicines daily before handing them over to the clinicians. The medicines were handed over back to the service manager at the end of each clinic by the clinician. There was a paper record which was signed and dated which showed what was used and what was returned to the service manager by the clinician.
- There was a record for ordering and receipt of medicines. The medicine records we looked were accurate and fully completed. All the medicines we checked were in date.
- We did not receive any information on whether service manager responsible for medicines management had received medicines management training as part of their role. We did not see any medicines management policy or restriction of access to authorised staff only.
- There was a clear audit trail for prescribing and administering of medicines by the doctors. The records we saw related to the administration of injections were fully completed by the doctor giving the injection.

Dermatology services for adults, children and young people

- At both dermatology clinics that we observed there were no medicines stored on site. Consultants or GPs wrote prescriptions for patients who attended the clinic. If an injection was required to be administered by the doctor, a prescription would be provided for the patient to collect and bring to their appointment.

Are services safe?

- We reviewed the most recent CQC reports of all three GP practices used for dermatology clinics and found that they all had safe systems in place for storing prescription pads and audits of their use.

Environment and equipment

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- The main reception waiting area was bright and clean with newspapers, magazines and toilet facilities. There was also a play area for children. Reception staff had a clear view of the entire area.
- There was a contract between the provider and the building management company. The building management company had the responsibility for some equipment checks, such as fire extinguishers. Evidence was kept at the clinic to confirm annual safety checks, such as for fire extinguishers, portable electrical appliances and equipment calibration, had been carried out. Stickers on each piece of equipment showed when it had been tested and when it was due to be retested. We saw up-to-date maintenance stickers for most of the equipment we looked at in the clinic.
- Equipment on trolleys used for clinics were checked, restocked and cleaned daily. We saw written evidence of this, and all the equipment was in date. Staff told us they had sufficient access to equipment they required.

Dermatology services for adults, children and young people

- The two dermatology clinics that we observed were held in local GP practices. The premises were clean and suitable for use.
- The service paid the GP surgery a nominal charge for each patient seen to cover the use of consumables, such as gloves. This ensured there were always appropriate supplies of these available.
- Liquid nitrogen was used within the clinics for cryotherapy (a procedure that uses extreme cold to remove lesions). We were told that there had been an issue in the past when it had run out at one of the clinics and this meant the procedure had to be rescheduled. There had been a change to practice and now a weekly check was undertaken so that this would not reoccur.

Quality of records

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- Staff used an electronic patient record system, which provided a record of the assessments, care and treatment required by and provided for patients.
- We reviewed 12 electronic patient records and we found that staff had recorded accurate information and all records had a timed and dated electronic signature.
- Staff used a secure, electronic system to record assessment and treatment of patients.

Cleanliness, infection control and hygiene

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- All patient waiting areas, consultation and treatment rooms, and private changing rooms were uncluttered, clean and tidy. Cleaning schedules for example for the treatment and consultation rooms were signed and up to date. The services provided single sex and disabled toilets and these areas were clean. Patients told us they found the clinic to be clean and well maintained.
- Staff were observed to be compliant with policies and guidance on the use of personal protective equipment, such as gloves and aprons which was readily available. We saw that 'Bare below the elbow' policies were adhered to.
- We saw, and patients reported, that staff washed their hands regularly before attending to them. The clinic provided hand sanitising gel for use by patients and staff and we saw these were being used appropriately.
- The clinic had an on-going contract with a clinical waste contractor. We saw different types of waste were appropriately segregated and stored prior to collection, including clinical waste and sharps.
- Records showed a risk assessment process for Legionella with appropriate processes in place to prevent contamination. We saw evidence of legionella sampling which had identified no contamination.
- Evidence provided to the inspection team showed 100% of staff had completed infection control training. Training was also scheduled for new staff and for those staff requiring an annual update.

Are services safe?

Dermatology services for adults, children and young people

- Hand sanitising gel was available in waiting areas and in clinic rooms. We saw doctors using this appropriately in between patients.
- The service paid the GP surgery a nominal charge for each patient which included responsibility for disposal of waste. We reviewed the latest CQC reports of all three GP surgeries used for dermatology clinics and found that all had effective systems in place to reduce the risk and spread of infection.

Mandatory training

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- Staff were up-to-date with their mandatory training. All staff were trained when they joined the service and most training were updated annually. The training data provided was for all staff employed directly by the service. Some sessions were practical and others were on line via an e-learning package. Sessions included infection prevention and control, equality and diversity, fire safety, basic and intermediate life support and manual handling.
- Staff we spoke with informed us the training was of a good standard and most did not have problems with finding time to complete it. Training for clinical and non-clinical staff was offered and tailored to meet their different needs.
- A standard vetting pack was received from the recruitment agency for all agency staff . This included training certificates, membership of any bodies and safeguarding training certificates.

Assessing and responding to patient risk

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- Basic equipment and emergency medicine (pocket face mask and 'epi-pen') for resuscitation were stored in each treatment room and were accessible to all staff. Records completed showed regular checks were undertaken to ensure the equipment and emergency medicine were safe to use.
- The service had trained first aiders and first aid kits. A first aid kit and accident book were available, as was a nebuliser. There was also a defibrillator and oxygen on the premises for use in an emergency. Medical staff were trained in the use of the defibrillator.
- Staff were all trained to provide basic first aid and call for an ambulance. Training records showed that all nursing staff had current basic life support training (BLS).
- The provider had systems and processes in place for responding to patient risk. Staff were available in the clinics so that they would detect patients who appeared unwell and needed assistance. Staff we spoke with demonstrated knowledge and understanding of patient risk, particularly for people living with dementia or learning disability.
- There were clear procedures for the care of patients who became unwell or patients who deteriorated whilst waiting at the clinic. Staff we spoke with told us about emergency procedures and the escalation process for unwell and deteriorating patients. However, they stated these had not been used regularly as the service did not often have acutely unwell patients.
- There were arrangements for transferring patients for emergency care. The clinic had a service level agreement with a nearby NHS acute hospital in case of an emergency. This meant patients who significantly deteriorated at any stage in their treatment would be taken by an NHS ambulance to the local emergency department.
- The service had arrangements in place to respond to emergencies and major incident.

Dermatology services for adults, children and young people

- The dermatology clinics were all situated within three GP medical centres and therefore the responsibility for supplying and maintaining the emergency equipment was held by each medical centre. We checked the previous inspection reports of both Tooting South medical centre and Southfields Group Practice (both published in July 2016) where we observed the dermatology clinics and found that both clinics had adequate arrangements to respond to emergencies and major incidents. We did not observe clinics at the third

GP surgery used for dermatology clinics, The Greyswood Practice as there were none on the day of our inspection. However we checked the last inspection report, published in July 2015, and found that they had adequate arrangements to respond in the event of an emergency.

- Both practices had defibrillators available on the premises and oxygen and emergency drugs accessible to staff to use and there was equipment for treating adults and children.

Staffing levels and caseload

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- The service did not directly employ their clinicians. The clinicians worked on a contractual and sessional basis. There were five GPs and three extended scope physiotherapist working at the service and their appraisals and revalidation were done by their substantive employers; we were told all the clinicians were up to date with their appraisal, supervision and revalidation. Evidence submitted by the provider confirmed all the clinicians were up to date with their appraisals and revalidation. Revalidation is the process by which all licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise in their chosen field and able to provide a good level of care.
- There was a large team of administrative staff including booking staff, receptionist and care co-ordinators. Staffing for the clinic was planned around the patient appointments scheduled to ensure staffing levels and skill mix were matched to the number and type of new and follow-up appointments.
- The management team had procedures in place to manage expected absences, such as annual leave and unexpected absences, for example staff sickness. Annual leave for staff was managed to ensure there were sufficient staff on duty each day to cover the needs of the service.
- All the staff we spoke with confirmed that they had undergone recruitment checks including Disclosure and Barring services checks, references and occupational health clearance, prior to taken up their role with the provider.

Dermatology services for adults, children and young people

- The service paid for consultants in dermatology and a GP with a special interest (GPSI) in dermatology to cover the dermatology outpatient's clinic sessions on a part time basis. The clinical lead for dermatology was a GPSI, however the clinical lead did not run clinics as the role was strategic to provide leadership and guidance. Clinics were run by other GPSI's and consultant dermatologists. Three consultants were provided by an agency and one GP with a special interest was a partner at one of the practices within the federation.
- Two consultants had been provided from the local acute hospital trust, however earlier in the year, they had moved onto other roles and could no longer run clinics. This had resulted in a reduction in the number of clinics being run. The service had prepared for this by employing consultants from an agency, however there had been an increase to the waiting times to access the service for patients from two weeks to between four and eight weeks.
- The service clinical lead told us that there was a shortage of dermatologists nationally and this meant that they had problems for recruiting. They said that they were looking at different options for provision of more consultants to run clinics.
- The agency and acute hospital providing the consultants supplied records of their competencies and mandatory training to the service and their records of revalidation. The clinical lead for the service conducted the appraisal of the GPSI. Revalidation was the individual doctor's responsibility and the service was provided with information that this had occurred.

Managing anticipated risks

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- The service had a system for reporting, recording and monitoring significant events. There were procedures in place to assess, manage and monitor risks to patient and staff safety. The building management company was responsible for all aspects of environmental safety. The provider ensured the appropriate checks and risk assessments had been carried out.

Are services safe?

- The service had a health and safety policy, which was accessible by all staff. Procedures were in place for monitoring and managing risks to patient and staff safety.
- We saw evidence that risk assessments were completed. For example, the clinic office risk assessment included slips trips and falls; working at height; display screen use and electrical faults.
- The service had clear policies and guidance for managing medical emergencies. Staff received basic life support training.
- There were emergency assistance call bells in all patient areas including consultation rooms and treatment rooms. Staff we spoke with told us when patients called for assistance whilst in the reception area; they were attended to by the reception staff immediately. Staff we spoke with were aware of their role in a medical emergency

Major incident awareness and training

Musculoskeletal Interface Clinical Assessment Service (MICAS) for Community adults

- There were arrangements to respond to emergencies and major incidents.
- There was a dedicated staff in charge of responding to emergencies, the staff was able to fully describe their responsibilities and the actions they would be required to take in an emergency.

Are services effective?

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

Summary

Battersea Healthcare Community Interest Company had systems and practices in place to ensure they provided an effective service. for example:

- Patient outcomes were reviewed as part of audits or quality improvement.
- Staff had the relevant skills, knowledge and experience to deliver the care and treatment offered by the service.
- The clinic shared relevant information with other services appropriately and in a timely way.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

Evidence based care and treatment

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- The service had local policies and guidelines. The policies we read were written according to national evidence-based guidance from organisations such as the Department of Health (DoH), the Chartered Society of Physiotherapy (CSP) and the National Institute for Heath and Care Excellence (NICE). Although audits were carried out against the guidelines, results were analysed to guide and improve practice.
- The service adhered to local policies and procedures. We spoke with all the clinicians and they described how they worked to NICE guidelines and best practice guidelines in their specialist fields.
- The service used clinical care pathways for musculoskeletal assessments. Patients had their needs assessed prior to treatment and were provided with care pathways which reflected best practice. Examples of these were seen where patients were referred for further physiotherapy input, given an injection by the GPSI or referred back to their GP.
- Staff followed standard operating procedures in line with best practice guidelines to determine each patient's referral and ongoing treatment pathways based upon the diagnosis.
- Patients were assessed at their first appointment and a treatment and exercise plan was set up. This was reviewed and updated on the next appointment where necessary. The service provided one appointment session per patient on average, the patient was then referred back to their GP or physiotherapy for further treatment and management.
- The provider policies reflected relevant legislation and local requirements and were accessible to all staff.

Dermatology services for adults, children and young people

- The provider assessed needs and delivered care in line with relevant and current evidence based guidance and standards such as the British Association of Dermatology (BAD) best practice guidelines.
- The dermatology service had conducted an audit of the use of Isotretinoin (a strong medication used for treating acne). This was completed to assess the documentation of the review of side effects in patients that had been prescribed the medication. The audit followed the British Association of Dermatology criteria and found that although all patients had lipids checked, only 10% of patients had a mental health assessment before starting treatment. Clear actions had been documented for where improvement was required and there were plans to change the electronic record in order that prompts could be provided to clinicians.
- If a patient required a biopsy or blood tests, an online template was completed by the doctor and sent to the booking office. We were told that results of biopsies would be sent to the referring clinician; however one doctor told us that it was frustrating as they didn't hear back from the acute hospital when the results were serious and that patient continued their treatment at the hospital. A blood report was run every two weeks by the booking office and results were uploaded onto the

patient's electronic record by the booking team. This was checked at the reminder telephone call and the bookings team would chase up results if they had not been received.

- The bookings office followed up on results such as blood tests for the patients and contacts them. They also provided a hard copy of the patient's records to the patient at no charge if they requested them.

Pain relief

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- Staff informed us if a patient required pain relief they would be assessed by the clinicians who would then write a prescription for them. This would be dispensed by the independent pharmacy. Staff informed us this rarely happened as most patients attending the clinic were mostly not in pain that needs pain relief.

Patient outcomes

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- Information about the outcomes of people's care and treatment was routinely collected and monitored, but the results were not always used to guide and improve practice. However, a patient satisfaction survey was carried out monthly and the results were compared with other Musculoskeletal outpatients services to improve care and services

Competent staff

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- Staff had the skills, knowledge and experience to deliver effective care and treatment. The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice and professional development needs. Staff had access to appropriate training to meet these learning needs to cover the scope of their work.
- Staff received mandatory training that included fire awareness and evacuation procedures, basic life support and information governance awareness. They had access to and made use of e-learning training modules and in-house training provided the service provider. Staff demonstrated they understood their responsibilities when we spoke with them and most had received training relevant to their role.
- The service had an induction programme for newly appointed members of staff that covered such topics as infection prevention and control, fire safety, health and safety, information governance and confidentiality.
- The provider checked doctors were fit to practise. We saw a record which included checks for valid indemnity insurance, Disclosure and Barring Service (DBS), annual appraisals and registration with the General Medical Council (GMC) and HPC. All the information provided were up-to-date.
- All staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment or when they took on new responsibilities. Clinical staff reported they were positively encouraged and given opportunities to develop and the management were keen for them to learn and improve.
- The learning needs of staff were identified through annual appraisals. Staff told us they had access to appropriate training to meet their learning needs and to cover the scope of their work. All staff we spoke with had had an appraisal within the last 12 months; the clinical staff had their appraisals in their substantive place of work and the administrative staff had their appraisals conducted by their line managers. Evidence submitted showed that 10 administrative staff had their appraisal completed and two were awaiting completion.
- Staff had skills, knowledge and experience to deliver effective care and treatment. The provider told us all new staff underwent an induction, and staff confirmed this when we spoke with them. The service demonstrated how they ensured role-specific training and professional development of staff were provided, for example, appointment booking staff had undergone training on handling telephone and managing patient's enquiries

Dermatology services for adults, children and young people

- There was no regular training led by the provider for the locum dermatologists or GPSIs. Training needs would

be identified on the annual appraisal for the GPSI and arranged accordingly. The locum dermatologists were responsible for managing their own continuous professional development.

- As part of their induction process locum dermatologists would be required to familiarise themselves with the policies before clinical sessions were booked. A Clinician's handbook had been developed to assist locum staff to easily navigate the policies and procedures followed by the service, which were all available on the intranet that was available from any computer.
- Within the last year there had been two dermatologists or GPSIs at each of the clinics which meant that the doctors could request a second opinion on a case easily within the clinic. Since the reduction in doctors from the local acute hospital, only one clinician was available in each clinic. One doctor told us that this meant that support was less readily available. This had been raised as a risk on the risk register and there had been mitigation put in place with a fortnightly support call by the service lead to the doctor concerned.
- The GPSI that conducted clinics had an accredited qualification in level three minor surgery and was also qualified to carry out cryotherapy.

Multi-disciplinary working and coordinated care pathways

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- Clinic staff worked together as a multidisciplinary team to meet patients' needs and to assess and plan ongoing care and treatment.
- Patient information such as assessments, investigation and treatment recommended were shared with the referring GPs.

Dermatology services for adults, children and young people

- The service had recently set up an intranet that was available via a website and therefore accessible to clinicians working remotely in GP practices. This had been communicated in the regular engagement meetings held with the GP practice groups.

Referral, transfer, discharge and transition

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- All contact and referrals went to through the head office and were distributed electronically to the appropriate named clinician for triage. Once the referral is accepted, the patient will be contacted by telephone to offer a suitable appointment to attend the clinic for assessment and treatment. For urgent referrals, the appointment team contacted the patient directly to ensure that the GP requests were expedited as soon as possible.
- There were clear and effective processes for staff to communicate between teams and when referring patients to other services including acute hospitals or back to their GPs.

Access to information

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- The information needed to deliver effective care and treatment was always available to staff. Referral information were received before an appointment was booked for patients.
- The clinic contacted GPs by letter to inform them of the treatment patients had received. Patients reported they received a copy of the letter to their GP and this usually arrived one to two weeks following their discharge from the clinic.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- The service did not have a standard consent form for the provision of joint injections; different clinicians used different consent methods: some used verbal consent and recorded the consent in the electronic patient records; others used paper based consent form.
- The electronic records we reviewed demonstrated that an appropriate consent was sought for all the injections given by the clinicians. Patient consent forms were completed fully and signed appropriately in the paper records we reviewed.

Are services effective?

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for patients who lacked capacity, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear, the GP or extended scope physiotherapist assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.
- The process for seeking consent was monitored through records' audits to ensure it met the clinic's responsibilities within legislation and followed relevant national guidance.

Dermatology services for adults, children and young people

- We observed patients, including a young person aged 16, being given information about options for treatment in order that they could give their consent. Thorough information was given verbally and in writing about the benefits and risks and time was provided for the patient to consider this before they gave final consent.
- The provider had a clear consent policy outlining consent procedures for children and young people which referenced Fraser guidelines and Gillick competences. This helped clinicians to make decisions about whether young people under 16 had the maturity, capacity and competence to give consent themselves, with the option for parents to countersign as well. A separate consent form was provided for the consent of treatment for children under the age of 16.

Are services caring?

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

Summary

Battersea Healthcare Community Interest Company provided caring service to service users. During the inspection we found:

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Staff respected patients dignity at all times and were sensitive to patient's needs and patients were always involved in planning their treatment and care.
- We observed staff explaining and ensuring that patients and carers had a good understanding of procedures before obtaining consent.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient confidentiality.

Compassionate care

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- We observed that members of staff were courteous and very helpful to patients and treated patients with dignity and respect.
- Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.
- Reception staff were able to offer patients who wanted to discuss sensitive issues or appeared distressed a private room to discuss their needs. We saw there was a private room available where patients could speak with staff confidentially. This contained informal seating and a coffee table and staff told us it was also used if patients were particularly emotional when the attended the practice.
- Most of the 22 CQC comment cards we received from patients were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.
- All the staff we spoke with told us they took time to be assured patients fully understood everything that went on during consultations. Written information was provided when it was appropriate so patients could refer to this following their appointment.

Dermatology services for adults, children and young people

- All doctors that we observed treated patients with respect and dignity during consultations. Curtains were used appropriately during physical examinations. In both the clinics we saw signs offering a chaperone and in consultations we heard doctors asking patients if they would like a chaperone during examinations.
- The clinics were located within GP surgeries and there was no information on view about how to feedback specifically about the services provide by Battersea CIC. Although concerns could be raised by contacting the booking office and there was a patient satisfaction questionnaire this was not a proactive way of receiving feedback from patients and families.

Understanding and involvement of patients and those close to them

Musculoskeletal Interface Clinical Assessment Service (MICAS) for Community adults

- Patients told us that 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. Patient feedback on the comment cards we received was also positive and aligned with these views.

Are services caring?

- The patients we spoke with told us they felt fully involved in decisions about their care and treatment and the GPs and nurses explained all aspects of their care to them in a way they understood. They told us they felt listened to and were able to freely express their opinions during consultations.
- We saw evidence that discussions about procedures and outcomes were recorded in patients' electronic records. Written information was available about the injections offered to MICAS patients.
- Staff made sure patients and their relatives were given information and time to ask questions about their care and treatment. Patients reported they were given as much time as they needed during the consultation and they were given leaflets when staff explained to them their treatment options.

Dermatology services for adults, children and young people

- In consultations that we observed, children and young people were provided with clear information about treatment options. This was provided verbally as well as with printed information sheets from the British Association of Dermatology (BAD). The patient was given information that enabled them to make decisions about the right care for them.
- The service ensured that patients were treated by the same clinician throughout their treatment. However, due to consultants leaving, some patients had to be transferred, and were apparently not always involved in the decision. For example, we observed an appointment where a patient had been expecting to see the consultant he had seen previously. As that consultant had left, he had been sent to a different doctor and there was not sufficient information on his record to enable the doctor to continue his treatment.

Emotional support

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- Patients said they had been emotionally well supported by staff.
- Staff demonstrated their understanding of the impact a person's care, treatment or condition might have on their wellbeing. They explained how different treatment options were discussed with patients and their relatives.
- Patients were helped and supported by staff to make their own decisions regarding their treatment.
- Staff had time to provide patients with support and information. One member of staff reported the best thing about working for the hospital was being able to "spend time with patients and not feel as though appointments were rushed."

Are services responsive to people's needs?

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

Summary

We found that Battersea Healthcare Community Interest Company was providing responsive care in accordance with the relevant regulations.

- The management reviewed the needs of its local population and engaged with the local Clinical Commissioning Group to secure additional services where needs were identified.
- Staff had a good understanding of the differing needs of the communities they served and made adjustments to account for patient preference regarding appointments and treatment options.
- The service was equipped to treat patients and meet their care needs.
- Information about how to complain was available and evidence showed the service responded quickly to issues and concerns raised.
- Learning from complaints was shared with staff and other stakeholders.

Planning and delivering services which meet people's needs

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- The provider worked with the local CCG to plan services and to improve outcomes for patients receiving MICAS services.
- We noted that services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care.
- The service planned services and delivered them to take account of people with complex needs. Staff told us they were informed by the doctors if a patient with complex needs was attending and any additional requirements for them were identified and provided.
- There was a good disabled access to the clinic, but in one of the consulting room, the patient examination couch was not height adjustable and not fit for some patients with disability.
- The service took account of the individual needs of different patient groups. Staff had access to information about different cultural, religious and spiritual needs and beliefs. A range of information leaflets were available in clinic areas.

Dermatology services for adults, children and young people

- Dermatology appointments were usually 10 to 15 minutes long. However the service offered a double appointment in circumstances where appropriate, such as where an interpreter had been booked.
- If a patient had mobility problems and need a taxi with wheelchair access, this could be arranged and paid for by the provider.

Equality and diversity

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- The service had access to a telephone translation service for patient who did not speak English as a first language. All patients were offered a translator when making an appointment.
- We did not find any evidence to suggest discrimination, including on grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief or sexual orientation in making care and treatment decisions. Staff went about their duties in an inclusive manner, affording attention to each patient on an equal basis, as required.
- We saw that all patients receiving treatment were treated as individuals. The management team told us equality and diversity training was delivered to all staff during induction. We noted there here were no equality and diversity champions within the organisation.
- The service was accessible to all, regardless of any disability. It was located on the ground floor level of a multiple occupancy building and there was a patient stair lift to other areas of the clinic. The corridors were wide and all rooms were wheelchair-accessible. There was also an accessible toilet at the clinic.

Are services responsive to people's needs?

Dermatology services for adults, children and young people

- There were inconsistencies with the services offered at each dermatology clinic. For example, we observed a patient attend a consultation expecting to receive a free treatment injection that they had received at another clinic run by the group. It was explained that this injection was only available for free at that location and at the other clinics, a prescription would be provided that the patient would collect and pay for and the doctor would administer. This meant that there was not equality of access to treatment across the service. As this was only raised as an issue on the day of the inspection, this had not been considered previously and therefore the service had not yet followed this issue up.
- The booking office would speak to patients in order to make the first appointment and if required interpreters could be booked in advance for clinics if the patient did not speak English.

Access to the right care at the right time

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- Patients were referred to the service via their GP, referrals were triaged by the clinicians, and an appointment made for the patient to attend for assessment and treatment. The clinical management of each patient on the waiting list was the responsibility of the clinician in charge of the patient's care ensuring they were put on the right pathway, whether routine or urgent, as well as by sub specialty.
- People had timely access to initial assessment or treatment. There was a patient access policy for 18 days referral to treatment (RTT) target. The referral to treatment waiting times for service was consistently better than the national target. From January 2016 to October 2016, patients received treatment within 7.1 days on average, which was better than the national target of 18 days. However, we were told the waiting times for the service were averaging between 4 – 8 weeks.
- The service opened Monday to Friday from 8am – 5pm, however, individual clinicians operated various clinic appointment times to suit their other work commitments. Clinics were held to suit the needs of the patients and clinicians; clinicians worked part time as independent contractors. Staff reported most patients were able to book appointments within the times offered by the clinicians. Most patients we spoke with said they were offered a choice of appointments, but if their appointment time was inconvenient they did not have any problems rearranging it. The service did not offer alternatives to face-to-face appointments such as using telemedicine, virtual clinics, skype or telephone consultations at this stage.
- Clinics ran on time and we observed this during our inspection. Patients we spoke with said they did not experience long waits from clinics running late and many reported being taken straight through to their appointment on arrival. When there were delays or other problems, patients we spoke with said they were kept informed and offered an alternative appointment if necessary.
- We were told waiting times, delays and cancellations were rare, and if there were any delays, these were minimal and managed appropriately. However, we were not given any data on cancelled clinics or waiting times. We were told and also observed that there was a minimal waiting time in clinics and most patients were seen as soon as they arrived. There were no delays during our inspection of this service, but staff told us they followed the providers protocol for delays and would tell patients about delays, if any and the reasons for them.

Dermatology services for adults, children and young people

- Dermatology referrals were received from local GPs. All patients living within the borough of Wandsworth were eligible to be referred to the dermatology service. Information about the service was cascaded to the GP practices as part of their monthly group meetings with the provider and as an email bulletin.
- The referrals were sent to the clinical lead who would triage each one and if they were assessed as suitable they would be added to the waiting list or they would be passed to secondary care at the local acute hospital. The clinical lead told us that they received an average of five to seven referrals a day.
- The service used a 'two week rule' criteria to identify urgent referrals and these would be referred onto an emergency secondary care clinic at the local acute

hospital. (A Two week rule criterion is the criteria for accessing the services within two weeks of referral). A clear process for this was available to clinicians via the intranet. The service also tried to leave appointment spaces within some clinics for other emergencies to be fitted in.

- In September and October 2016, we were told that waiting times for dermatology had been about two weeks; however they were now between four to eight weeks due to the cancellation of clinics as a result of shortage of dermatology doctors at the local acute hospital that had provided doctors for clinics. We were told that there had been delays in the past for similar reasons and so the provider now used doctors from an agency in order to avoid greater impact to the service.
- When an appointment was available for a new patient referral, the bookings team would contact the patient in order to discuss the options for them. The nearest clinic to their home address was usually offered, however, if the patient had a preference for another location, this would be accommodated.
- The 'did not attend' (DNA) rates for dermatology appointments between April 2016 to December 2016 were an average of 12%. We were told that all patients received a telephone call seven days prior to their appointment to remind them of their appointment. If this was not answered then a voicemail message would be left and a letter sent as a reminder. The service had undertaken a 'Did Not Attend' DNA audit in October 2016 to identify why people failed to attend their appointment with the aim of reducing the rate. This found that where there was no contact from the seven day phone call, despite sending a letter, this had resulted in the highest amount of DNAs. The service had initiated a text reminder system two days before the appointment to improve the DNA rate.
- A card was provided to patients who attended clinics as a record of the appointment they had attended and which professional saw them. This had a telephone contact number and email address for the patient to contact the bookings team directly.
- The patient satisfaction survey for November showed that out of 24 returns the average waiting time to see the dermatologist was eight minutes with only one out of 24 returns waiting longer than 20 minutes.

Learning from complaints and concerns

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- There was a complaint policy, which provided staff with information about handling formal and informal complaints from patients. Comprehensive information for patients about how to make a complaint was available on the service website and there were also some leaflets in the clinic waiting area. This is included details of other agencies to contact if a patient was not satisfied with the outcome of the service investigation into their complaint. There was a notice in the general reception area (this was a shared reception area with the GP Practice) informing patients how to make a complaint.
- We saw the summary of complaints that had been received in the 12 months prior to our inspection. A summary of the complaint, details of the investigation, the person responsible for the investigation and whether or not the complaint was upheld was recorded. The service received and investigated three complaints and two were upheld.
- We looked at the most recent complaints the practice had investigated. We saw that these had all been thoroughly investigated and the patient had been communicated with throughout the process. The provider was open about anything they could have done better, and there was a system in place so learning as a result of complaints received was disseminated to staff.
- All the staff we spoke with were aware of the system for dealing with complaints. They told us feedback was welcomed by the provider and seen as a way to improve the service.
- We also reviewed complaints that had been made by patients. We saw that these had been investigated, with patients being given full feedback about their concerns. Evidence was provided that where necessary support or refresher training was given to staff so that improvements could be made.

Dermatology services for adults, children and young peoples

- There were a very low number of complaints reported by the service. Only three in the last year.

Are services responsive to people's needs?

- The clinics were located within GP surgeries and there was no information on view about how to complain specifically about the services provide by Battersea CIC. We were told that concerns would be raised to the administrative office on the telephone, and they would be dealt with at the time. It was not clear if these would be documented and learning from these concerns shared to prevent the risk of future occurrences.

Are services well-led?

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

Summary

We found Battersea Healthcare Community Interest Company was providing well-led care in accordance with the relevant regulations.

- The service had a governance framework that supported the delivery of quality care. Risk assessments were carried out to identify and reduce any identified risks to service users and staff.
- There was a clear leadership structure that supported staff to develop. Staff made positive comments about the local leadership of the service and the support they received. Staff felt respected and valued by their colleagues and their managers.
- The service encouraged and valued feedback from patients, the public and staff.
- The culture of the service was one of openness and transparency. The local leadership shaped the culture through effective engagement with staff and service users.

However

- There was inconsistency in staff awareness of the vision, values and strategies of the service; this was not communicated to staff clearly.
- Most of the staff we spoke with could not articulate the values, vision and strategy of the service. The knowledge of these were centred around the senior management team.

Service vision and strategy

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- The service was commissioned to provide a musculoskeletal outpatient services for the residents of the London Borough of Wandsworth.
- There was no specific vision for the service and only the senior management were aware of the corporate vision. We were told that there was strategy for the service however the strategy together with the vision was not formally documented and communicated to staff.

Governance, risk management and quality measurement

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- We saw systems in place for monitoring all aspects of the service such as complaints, incidents, safeguarding, risk management, clinical audit and infection control.
- There was a management team who oversaw the systems, ensuring they were consistent and effective. The management team covered all the services run by the provider. The management team were responsible for making sure policies and procedures were up to date and staff received training appropriate to their role.
- A programme of audits was in place to monitor quality and to make improvements. We saw evidence of clinical audits monitoring outcomes for patients such as medicine and records audits from which improvement action plans were developed.
- There were arrangements in place to identify and manage risks. We saw evidence of environmental risk assessments and the providers' health and safety policy.
- The risk register contained 56 risks; of these none were rated 'red', 26 were rated 'amber', 25 were rated 'yellow' and five were rated 'green'. Those risks with a risk level above eight were reviewed by the board.

Dermatology services for adults, children and young people

- Children and young people were represented on the board by the safeguarding lead.
- The main risk identified to the dermatology service by staff we spoke with was the shortage of dermatologists. We were told that this issue was on the risk register. When we reviewed the risk register we found that there was a risk listed for losing the acute hospital as a provider of services. This had mitigations, such as the employment of locum dermatologists and consideration of other service providers to ensure the continuity of the dermatology services.

Are services well-led?

- The service had a monthly multidisciplinary (MDT) meeting for each of the dermatology and MICAS services. The dermatology MDT was held with the service manager, the head of operations and clinicians at the local acute hospital. This meeting discussed specific issues, such as the dermatologist recruitment problems and looked at ways the services could work together.

Leadership of this service

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- The management team had the experience, capacity and capability to run the service and ensure high quality care. They prioritised safe, high quality and compassionate care. The management were visible in the clinic and staff told us that they were approachable and always took the time to listen to all members of staff. Each of the two services provided have clinical leads and the overall service is led by the medical director and chief executive who reports to the board of directors.
- Managers had a strong focus on the needs of patients and the roles staff needed to play in delivering good care.
- Staff felt supported by management. Staff told us regular team meetings were held and we saw minutes of meetings. Staff said there was an open culture within the service and they had the opportunity to raise issues at team meetings.
- There was a clear leadership structure, but there was no scheme of delegation. Day to day running of the clinic was the responsibility of the registered manager. We saw evidence of regular meetings including monthly governance meetings, executive and board meeting

Dermatology services for adults, children and young people

- The dermatology service had an aim, which was to provide a 'one stop shop' for patients with skin problems. This meant a biopsy could be taken, phototherapy offered and a follow up appointment made at the same appointment.
- Doctors we spoke with said that they would be happy raising issues and concerns and stated that senior managers were always available and had an 'open door' approach.

Culture within this service

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- We spoke to eight members of staff about the organisation culture and all of them reported that they enjoyed their jobs and felt valued. They all made particular reference to the no blame culture within the service and felt able to raise concerns.
- We asked staff about opportunities for professional development. Staff had yearly appraisals including supervision. Staff felt supported to develop and managers told us that they supported their staff to develop.
- Staff spoke of the positive approach of the service when caring for patients and were positive about how the philosophy of the service was to put patient first.
- All the staff we spoke with were positive about the organisation and how they felt valued working within it.
- Staff we spoke with told us they would feel able to raise any concerns but had not had the need to do so.

Staff and public engagement

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- The service encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.
- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management, although there was no formal process in place to gather staff views. Staff told us they felt involved.
- Leadership within the service was positive, visible and proactive. Managers had a strong focus on the needs of patients and the roles staff needed to play in delivering good care.
- Staff spoke highly of the senior management team and told us they felt very valued by senior managers and the

board. They felt the board members were very visible and approachable. We heard of examples of staff feeling comfortable with raising concerns with the management and where this had been acted upon.

- Staff told us their managers were visible and communicated with them in person and via an email bulletin. Staff had the opportunity to discuss concerns or queries in daily meetings. Staff received thanks from the chief executive for work which was undertaken.
- There was good clinical leadership from the medical director who was the lead clinician for the service. The service had developed considerably in the last twelve months since becoming a community interest company. This was supported by one of the GPs having a designated clinical advisory position. This allowed him to better engage with other GPs and the CCG.
- The service offered the option for patients to complete a satisfaction questionnaire. Results of this were circulated on email to the integrated governance committee and to the board. The results from November 2016 showed that out of 24 returns, six of the questions had a positive response of greater than 95%. One question about the usefulness of the information contained in the appointment letter had a slightly lower positive return of 87%. There was a record of these being discussed at the integrated governance committee although there were no actions for the dermatology service. There was no alternative method of gathering feedback from the children and young people using the service.

Innovation, improvement and sustainability

Musculoskeletal Interface Clinical Assessment Service (MICAS) for community adults

- Battersea Healthcare supported staff learning through its induction and training programme.
- There was a clear leadership structure and staff felt supported by management. Staff told us the practice held regular team meetings, and provided minutes to this effect.
- Administrative staff said they felt respected, valued and supported by the clinicians and the senior management team. They appreciated being given lead roles in areas such as dealing with medication ordering and storage, booking of patients etc., as it allowed them to take on more responsibility.
- Clinical staff worked on contractual basis and were involved in discussions about how to run and develop the service; they were keen to share their ideas for development and improvement.
- All staff were aware of the provider's whistleblowing policy, and aware of where to find a copy.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12.— Safe care and treatment (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include —the proper and safe management of medicines, • There was no dedicated clinician input for medicines management. • Medicines used at the clinic were being managed by a person who was non clinician. • The provider did not have appropriate medicine storage facilities.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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