Medvivo

Inspection report

Greenways Business Park
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	**Good** ●
Are services effective?	**Good** ●
Are services caring?	**Outstanding** ☆
Are services responsive?	**Outstanding** ☆
Are services well-led?	**Outstanding** ☆

Overall summary

This service is rated as Outstanding overall. (Previous inspection February 2017 – Outstanding)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Outstanding

Are services responsive? – Outstanding

Are services well-led? – Outstanding

We carried out an announced comprehensive inspection at Medvivo on 22-24 January as part of our inspection programme.

At this inspection we found:

- The service had good systems to manage risk so that safety incidents were less likely to happen. When they did happen, there was a focus on openness, transparency and the service learned from them and improved their processes.
- The service routinely reviewed the effectiveness and appropriateness of the care it provided. Evidence base guideline updates were regularly cascaded to staff. However we found in the sample of medical records reviewed that documentation was not always in line current best practice and guidance. Staff involved and treated people with compassion, kindness, dignity and respect. Patients were valued as individuals and were empowered to have a voice in their own care.
- Patients could access care and treatment from the service within an appropriate timescale for their needs. Care was person centred and services were tailored and delivered to meet the needs of an individual in a way that ensured flexibility and choice.
- There was a strong focus on continuous learning and improvement at all levels of the organisation and the culture ensured all staff were engaged to deliver high quality person centred care.

We saw several areas of outstanding practice:

- The provider worked collaboratively with external stakeholders on a range of initiatives to improve access to care and patient experience for those who were vulnerable, had a disability or were from a minority group. An example of this was use of the Streetlink homelessness App and delivering care for refugees being repatriated to the UK.
- There were innovative approaches to providing integrated patient-centred care. For example, the provider delivered an Urgent Care @Home service. The service ensured an integrated rapid health and social care response for service users in a health or social care crisis in their own home to avoid inappropriate admissions and expedite hospital discharges. This had not only improved patient outcomes but it has also supported the whole system in terms of increased capacity and financial savings.
- There was a strong emphasis on staff wellbeing. The interventions initiated by the provider had led to a decrease in turnover of over 6% in the last 12 months. Examples of initiatives taken were a Health and Wellbeing Charter developed with staff, the introduction of Mental Health First Aiders, resilience workshops and self-awareness campaigns.

The area where the provider **should** make improvements:

- Improve and monitor documentation of consultations, to ensure they are consistently in line with best practice and current guidance.

Dr Rosie Benneyworth BS BM BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC Lead Inspector. The team included an urgent care GP specialist adviser, a CQC inspector and two CQC Inspection Managers.

Background to Medvivo

Medvivo is the registered location for services provided by Medvivo Group Limited and is registered to provide services from Fox Talbot House, Greenways Business Park, Bellinger Close

Chippenham, Wiltshire SN15 1BN The service covers a population of approximately 900,000 people across the counties of Wiltshire, Bath and North East Somerset and Swindon. The service is a large employer, with between 500 and 600 staff and 147 sessional GPs. Deprivation across the area overall is lower than the national average and it has relatively low numbers of patients from different cultural backgrounds. Medvivo provides a number of services for patients in this area which include:

- NHS 111 service, delivered through a formal subcontract arrangement with another provider. (NHS 111is a telephone based service where people are assessed, given advice and directed to a local service that most appropriately meets their needs).
- Clinical Assessment Service in which healthcare professionals determine the most appropriate pathway that will best meet patient needs.
- The Access to Care service which provides a single point of access, via a direct dial telephone number for health professionals and identified patients. This provides a single point of access is to act as a referral mechanism into both the integrated community teams and the community hospitals in Wiltshire.
- Urgent Care and at home response team (UC@H) provides rapid health and social care response for people experiencing a crisis in their own home in Wiltshire.
- Urgent Care Clinic (SUCCESS) and Children's & Young Person's clinics (CYPC) in Swindon. These services provide additional capacity for urgent demand for patients accessing primary care within this area.
- GP resilience support, providing in hours support for practices in Wiltshire where there is a need.
- GP Out of Hours (OOH) services across BaNES, Swindon and Wiltshire where care is delivered from nine sites across the area:
  - Chippenham Community Hospital, Rowden Hill, Chippenham, Wiltshire, SN15 2AJ (open 6.30pm until 8am Monday to Friday and 24 hours over weekends and bank holidays)
  - Salisbury Hospital NHS Foundation Trust, Odstock Road, Salisbury, Wiltshire SP2 8BJ Emergency Department (open 6.30pm until 8am Monday to Friday and 24 hours over weekends and bank holidays).
  - Trowbridge Community Hospital, Adcroft Street, Trowbridge, BA14 8PH (open 6.30pm until 8am Monday to Friday and 24 hours over weekends and bank holidays)
  - Savernake Community Hospital: Savernake, Marlborough, SN8 3HL. open from 7.30pm until midnight weekdays and 8am until midnight weekends and Bank Holidays)
  - Warminster Community Hospital, The Avenue, Warminster, BA12 8QS (open 7.30pm to midnight weekdays and 9am to 11pm at weekends and Bank Holidays).
  - Devizes Community Hospital, Family Health Centre, Couch Lane Devizes, SN10 1EF (open 12pm to 6pm Saturdays only)
  - Royal United Hospital, Coombe Park, Bath BA1 3NG (open 6.30pm – 8am weekdays and 24hrs weekends and bank holidays.
  - Paulton Minor Injuries Unit, Salisbury Road, Bristol BS39 7sb (open weekends only 8am – midnight)
  - Swindon NHS Health Centre, 1 Islington Street, Swindon, SN1 2DQ (open 8am – 8pm daily)
  - Moredon Medical centre, Moredon Road, Swindon SN2 2JG (open 8am – 8pm daily

We visited the sites at Royal United Hospital, Trowbridge, Chippenham, Savernake and Swindon (this included the OOH service and both the in hours SUCCESS and CPYC clinics) as part of this inspection.

Medvivo Group Limited is registered to provide the following regulated activies:

- Treatment Disease, disorder and injury

- Personal Care
- Transport services, triage and medical advice provided remotely

Good

Are services safe?

We rated the service as good for providing safe services.

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- The provider conducted safety risk assessments. It had safety policies, including Control of Substances Hazardous to Health and Health & Safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the provider as part of their induction and refresher training.
- The provider had comprehensive systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance. We saw examples where learning of safeguarding incidents was shared with Medvivo staff, via the weekly clinical review bulletin and quarterly non clinical round up e-magazine.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. In addition to on line training the safeguarding lead for Medvivo delivered face to face safeguarding training for their staff. This bespoke training included utilisation of case studies that Medvivo had dealt with during the past 12 months to ensure staff were able to fully relate to the training.

The service worked with other agencies to support patients and protect them from neglect and abuse. Examples of this were:

- Medvivo had been commissioned to be the Primary Care Liaison lead for the Multi-Agency Risk Assessment Conference (MARAC). The meetings facilitated the sharing of information of those at highest risk of domestic homicide between other agencies, including, the Police, child protection services, probation and other healthcare specialists. Following MARAC meetings Medvivo shared information with the patients GP surgery and communicated any requested actions that need to be taken by the GP. Data for meetings that took place during July – September 2018 showed that 776 patients were discussed and 624 had special notes added to their medical record ensuring clincians across primary care ensuring that the potential to keep these patients safe was improved.
- Medvivo ensured that when a safeguarding matter was raised the patients GP would be contacted and where possible, spoken to in person. This was in addition to the standard post service messaging system to ensure any necessary actions were taken.
- To ensure oversight and consistency of safeguarding processes, all referrals made by the subcontracted NHS 111 service, were monitored by Medvivo and followed up where necessary.
- Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Staff who acted as chaperones were trained for the role and had received a DBS check. We saw notices in the waiting room of sites that we visited that advised patients that chaperones were available if required.
- There was an effective system to manage infection prevention and control. Annual infection control audits were undertaken including audits at each base site and handwashing audits. We saw evidence that action was taken to address any improvements identified as a result.
- The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. Staff rotas were mapped against activity and demand profiles, including seasonal variation. Live shift management was in operation in order to monitor delivery and the impact on safety. They implemented additional resource

should it be required due to unexpected sickness or surges in demand. For example, the ability for GPs not on rota, to carry out remote triage via secure computer systems, for short periods of time.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis. In line with available guidance, patients were prioritised appropriately for care and treatment, in accordance with their clinical need. Systems were in place to manage people who experienced long waits.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The service had systems for sharing information across the providers different services, with staff and other agencies to enable them to deliver safe care and treatment. Such as, sharing information around vulnerable patients, who would benefit from other services they delivered such as the at home response service.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Appropriate and safe use of medicines

The service had reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, including medical gases, emergency medicines and equipment, and controlled drugs and vaccines, minimised risks. The service kept prescription stationery securely and monitored its use. Arrangements were also in place to ensure medicines and medical gas cylinders carried in vehicles were stored appropriately.
- The service carried out regular medicines audit to ensure prescribing was in line with best practice guidelines for safe prescribing. For example, antimicrobial stewardship had been audited on a regular basis. Educational material on antimicrobial stewardship was available on the intranet site for staff and information for patients at the clinical sites.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.
- Processes were in place for checking medicines and staff kept accurate records of medicines.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately.
- Palliative care patients were able to receive prompt access to pain relief and other medication required to control their symptoms. They were given a separate number to call so that they could have direct access to healthcare professionals.

Track record on safety

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- A weekly risk meeting provided a focus for risk management throughout the organisation. This ensured that controls were in place to avoid or manage incidents that had occurred. The meeting consisted of reviewing recently closed incidents, to ensure all actions had been completed, a review of outstanding incidents and a review and action plan for all newly raised incidents. Learning from incidents was shared via weekly e-newsletters with staff and with sub-contracted services.
- There was a system for receiving and acting on safety alerts. We saw that these had been cascaded to relevant staff and actions were taken and fed back to management when completed. Information to clinicians regarding changes to practice was cascaded in the weekly clinical bulletin.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

Good

Are services safe?

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- In order to maintain oversight, the provider ensured that the provider of the NHS 111 subcontract reported all incidents to them. This meant they were able to monitor risk to patients and ensure a consistent approach to safety.

The provider took part in end to end reviews with other organisations. All incidents underwent a root cause analysis and lessons learned used to make improvements.

For example, following an incident with the subcontractor when a call handler's headset had not been turned off at the end of the shift, a number of calls were lost. Contact was established with all except five of the patients whose call had not been answered. Following a root cause analysis, actions were implemented to minimise the risk of the situation arising again, including a second check by the team leader that all headsets are turned off. Medvivo ensured further patient safety by ensuring these actions had been implemented and asking their own IT team to review telephony to ensure that calls would be diverted to another call handler if unanswered after a number of rings.

Good

Are services effective?

We rated the service as Good for providing effective services.

Effective needs assessment, care and treatment

- The provider had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. NICE guidance updates, in easy to read format were distributed electronically to all clinical staff on a quarterly basis. The latest clinical roundup included updated guidance for ten disease areas, including Irritable Bowel Syndrome and Urinary Tract infections. Urgent updates were shared with staff via the weekly clinical digest. The organisation was able to monitor receipt and reading of these communications by staff.
- The provider carried out clinical consultation audits using the clinical guardian software for the services offered via the adastra platform, which comprised their core work. Cases from the other two systems were not routinely audited. However, GPs working on these systems also worked within Adastra where their clinical consultations were subject to regular audit. We reviewed 30 patient medical records for the three systems. Of the 11 we reviewed for the system used for the practice resilience programme, which were not being specifically audited, we found that the documentation for six of records did not adhere to guidance and indicated that there was a potential to put patients at risk. Following the inspection, the provider undertook an independant review of these which demonstrated that patients had received appropriate care in line with guidelines. The provider told us that they had also spoken to GPs where documentation fell below expected standards, in order that this should improve. We were also told that the provider had initiated a manual system of audits until the two clinical systems could be integrated with the clinical guardian system for auditing purposes.

Telephone assessments were carried out using a defined operating model. Staff were aware of the operating model which included live transfer of calls from call handler to clinician and the use of a structured NHS Pathways assessment tool.

- Clinical assessments were carried out using structured assessment tools such as the National Early Warning Score (NEWS2) and the Paediatric Early Warning Score (PEWS) to identify those who were at risk of developing Sepsis.
- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- Care and treatment was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. For example, management plans for vulnerable people were documented within enhanced summary care records and IT systems were configured so that safeguarding alerts from the local authority were availiable to clinicians.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat patients. For example, risk assessments were undertaken on each occasion, regarding the risk of repeat prescribing to a patient unknown to the clinician and the risk, if a patient was not supplied with a prescription. Standard operating procedures were in place to support clinicians with this process.
- There was a system in place to identify frequent callers via monthly high caller reports. Medvivo had worked with the NHS 111 provider as part of their integrated urgent care service delivery, to support these patients and reduce the number of calls received.
- We saw no evidence of discrimination when making care and treatment decisions.
- When staff were not able to make a direct appointment on behalf of the patient, clear referral processes were in place. These were agreed with senior staff and clear explanation was given to the patient or person calling on their behalf.
- Technology and equipment were used to improve treatment and to support patients' independence. For example, the MiDos App had been installed onto the drivers' mobile phones, so that they could easily access information for patients, about when and which local

pharmacies were open. We also saw that due to potential difficulties obtaining mobile signals in the rural part of the area each base car, carried two mobile phones which were on different networks.
- Staff assessed and managed patients' pain where appropriate using recognised pain assessment tools.

Monitoring care and treatment

The service had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example, responders were assessed during monthly joint visits with supervisors and feedback was given where appropriate to improve standards of care.

Providers are required to report monthly to their clinical commissioning group (CCG) on their performance against the standards which includes: audits; response times to phone calls: whether telephone and face to face assessments happened within the required timescales: seeking patient feedback: and, actions taken to improve quality.

- The provider had subcontracted the NHS 111 service of the Integrated Urgent Care contract to Vocare, however, the provider maintained oversight and held the overall responsibility and accountability and reporting to the commissioners for performance delivery. Where performance was not in line with key performance indicators (KPIs) the provider managed these appropriately. For example, requesting hourly updates from Vocare to the Medvivo management if calls answered within 60 seconds fell below 70%. NHS 111 data demonstrated:
  - Weekly performance data for calls answered within 60 seconds (for which the target is 95%) varied between 70% and 90%. Available data for December 2018 and January 2019 showed improvement with the mean average of 85% of calls answered within 60 seconds. This was in line with national averages. The average length of time for a call to be answered within 30 seconds for quarter two 2018/19 was 41 seconds which was an improvement from the previous quarter of one minute and seven seconds.
  - Weekly performance data for the number of calls abandoned (the national target is less than 5%) showed the service was mainly in line or performing better than the national target. (Abandonment rates indicate the number of service users who abandoned the call. This can indicate risk to patients with a serious illness being unable to access timely treatment). The average number of calls abandoned for a call to be answered for quarter two 2018/19 was 3.5% which was an improvement from the previous quarter of 6%.
  - Data for the disposition times for home visits demonstrated for the period May – October 2018 that 57% of patients were seen within the urgent – 2 hours category and 86% within the routine- 6 hours category. In recognition that this needed to be improved the provider had audited, to highlight areas for improvement. It was identified that due to poor mobile reception clincians were not recording the visit on the system until they returned to base which affected the disposition times. They also identified a training need regarding use of the system by staff. We spoke with the commissioners who were aware of these issues and who told us they were assured that the data did not reflect the quality of care patients were receiving.
- The service had locally agreed key performance indicators (KPI's) as set by the commissioners. These were agreed prior to the start of the Integrated Urgent Care (IUC) contract and national standards had not been set by NHS England at this time. The commissioners had decided not to set targets for the first nine months of the contract, other than those associated with the NHS 111 service. Medvivo reported monthly to the commissioners and much of the data was reported as numbers of patients, as agreed with the commissioners in order to facilitate future resourcing modelling. We spoke with the commissioners who told us that the provider was performing well and meeting their expectations Following the recent publication of NHS England standards, specific targets would be set at the end of February 2019. The reporting format showed that for the period July - September 2018:
  - The average time, for a patient receiving an urgent clinical assessment was 17 mins. This figure had remained stable throughout the period.
  - The average time to a definitive clinical encounter was 56 minutes. This figure had steadily decreased from 1hour and 13mins over the reporting period.

  - The percentage of calls that were booked for a face to face appointment with a clinician within a primary care setting was 24%. This figure had remained stable over the reporting period.

- Out of 15,240 patients triaged by the Clinical Assessment Service (CAS) September – November 2018 showed:
  - 58% of patients triaged by the CAS needed no further follow up.
  - 29% were referred for a face to face consultation with an out of hours GP.
  - 7% were referred to secondary care.
  - 2% were referred to the emergency services.
  - 1% were referred to other services such as the mental health or palliative care services.
  - 2% of patients were recorded as a failed encounter. These underwent a risk assessment by a member of the clinical team. If considered medium or high risk, allied services such as local hospitals were contacted and if required a welfare visit was arranged.
  - Outcomes from referrals into the CAS from the ambulance service demonstrated admission avoidance. 71% of the cases were either closed with no follow up or referred to a primary care or community service.
- The service made improvements through the use of audits. For example, cases where a broad spectrum antibiotic had been prescribed, (antibiotics which are most likely to develop resistance if used inappropriately) were audited to ascertain if best practice was being adhered to. The initial audit showed that of these cases, 47% did not meet best practice. Individual clinicians received feedback; they were asked to reflect on their practice and reminded of the antibiotic guidelines. A follow up audit demonstrated that the interventions had made a positive impact, as 90% of these antibiotics had been prescribed according to best practice.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified.
- The provider had an induction programme for all newly appointed staff. Induction for all staff consisted of a two day corporate induction, which included, a strategic overview, Medvivo's vision and values, safeguarding and incident reporting, HR and IT and mandatory training modules such as information governance. Additionally, specific role specific inductions were mapped out for all new starters. Staff we spoke with told us that the induction they had received was comprehensive and relevant to their roles.
- The provider ensured that all staff worked within their scope of practice and had access to clinical support when required.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Staff were encouraged and given opportunities to develop. The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high quality care. Staff were proactively supported to acquire new skills and share best practice. For example, all responders (staff who deliver non clinical interventions and support services) were encouraged to undertake the Care Certificate, supported by the organisations trained assessors. There was a strategy to invest in two nurses per year to develop them into Advanced Nurse Practitioners in order to provide ongoing home-grown talent providing resilience for the future. Sessional GPs were given access to the provider's e-learning data base and were offered attendance, at available face to face learning.
- Recent interventions to strengthen leadership competencies had included the introduction of a bespoke management course developed by Medvivo and a competency framework for managers. A new medical director was being mentored by her predecessor.
- Study days for nurse practitioners, paramedics and pharmacists were held three times a year. We saw that these included, non medical prescribing, paediatrics and end of life care, however some staff reported difficulties attending these sessions due to clinical commitments

The provider provided staff with ongoing support. This included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. Nurses told us during the inspection, that clinical supervision was not mandatory however the service provided clinical supervision for staff who did not have support elsewhere.

- The provider could demonstrate how it ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.

Good

Are services effective?

- There was a clear approach for supporting and managing staff when their performance was poor or variable. For example, we saw from clinical call audits, clinicians were asked to reflect on patient management if the care delivered was considered not to be in line with best practice.

Coordinating care and treatment

Staff worked together, and worked well with other organisations to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. Care and treatment for patients in vulnerable circumstances was coordinated with other services. For example, Medvivo's lead role for the area at the Multi-Agency Risk Assessment Conference (MARAC) meetings and the over 80 pathway for patients calling NHS 111. Staff communicated promptly with patient's registered GP's so that the GP was aware of the need for further action. Staff also referred patients back to their own GP to ensure continuity of care, where necessary. There were established pathways for staff to follow to ensure callers were referred to other services for support as required. The service worked with patients to develop personal care plans that were shared with relevant agencies. For example, treatment escalation plans (TEP) and individual end of life pathways.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way. Prior to the mobilisation of the integrated urgent care contract, across an area which utilised a number of different clinical recording systems, Medvivo led discussions with stakeholders on the technological options regarding an urgent care clinician's ability to access adequate information to support clinical decision making at the point of care. Technological solutions included, a system whereby uploaded data was aligned to a patients TEP and a system that enabled access to shared information relating to child welfare and safeguarding alerts held within the local authority system.
- The service had formalised systems with the subcontracted NHS 111 service with specific referral protocols for patients referred to the service. An electronic record of all consultations was sent to patients' own GPs.
- The service ensured that care was delivered in a coordinated way and took into account the needs of different patients, including those who may be vulnerable because of their circumstances. For example, bespoke pathways had been developed to enhance patient care for the under five years, over eighty years, those at the end of their life and those experiencing mental health issues.
- There were clear and effective arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that require them. Staff were empowered to make direct referrals and/or appointments for patients with other services.
- Issues with the Directory of Services (DoS) were resolved in a timely manner. Medvivo had worked with the commissioners to ensure DoS profiles and DoS rankings were set to channel activity to lower acuity services and away from the Ambulance Service and Emergency Departments where appropriate.

Helping patients to live healthier lives

Staff were consistent and proactive in empowering patients, and supporting them to manage their own health and maximise their independence.

- The service identified patients who may be in need of extra support. For example, patients over 80 years old, where increased case complexity is common and known to lead to difficulties for call handlers in completing the NHS Pathways assessment. As these could result in inappropriate referral to Ambulance and the Emergency department, these were passed on for assessment by a clinician.
- Where appropriate, staff gave people advice so they could self-care. Systems were available to facilitate this.
- Risk factors, where identified, were highlighted to patients and their normal care providers so additional support could be given.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their need.

Consent to care and treatment

Good

Are services effective?

The service obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

The provider monitored the process for seeking consent appropriately.

Outstanding ☆

Are services caring?

We rated the service as outstanding for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Patients were valued as individuals and were empowered to have a voice in their own care.

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information. Call handlers gave people who phoned into the service clear information. There were arrangements and systems in place to support staff to respond to people with specific health care needs such as end of life care and those who had mental health needs.
- A sympathy card had been designed for urgent care at home responders (UC@H) to take to families who had suffered bereavement during the previous week.
- Following a Christmas box appeal, 35 boxes, containing food and treats, were delivered to those service users who had been identified by the UC@H, as being in need or those who would be alone over the Christmas period.
- Of the 58 patient Care Quality Commission comment cards we received 56 were wholly positive about the service experienced. Comments included praise for the efficiency of the service from the initial call to NHS 111 to being seen at one of the services sites and the professionalism of the staff.

Patient feedback that had been collected by the service for the out of hours GP service from April – December 2018 showed that patients were continually positive about the way staff treated people and reported positive outcomes from their care and experiences, for example of the 55 respondents:

- 100% agreed or strongly agreed that they were treated with dignity and respect and
- 100% agreed or strongly agreed that they had received the support required from the service.
- 98% agreed or strongly agreed that they felt involved in decisions about their care.
- 98% would recommend the service to their family and friends.
-

Feedback collected by Medvivo for the Urgent Care at Home service from April - December 2018 showed that for the 22 respondents:

- 100% agreed or strongly agreed that they had received the support required from the service.
- 98% agreed or strongly agreed that they were treated with dignity and respect.
- 98% agreed or strongly agreed that they felt involved in decisions about their care.
- 100% would recommend the service to their family and friends.
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The service had recognised children and young people could be high users of urgent care and had recently introduced specially designed feedback cards specifically for this age group. Of the eighteight responses received at the time of the inspection, all respondents said that they felt that it was a good service to look after friends and family if they needed similar care or treatment to them. Comments included how easy and nice the doctor or nurse was to speak to.

- Patients we spoke with during the inspection spoke highly of the service and reflected the comment cards and survey results.

Involvement in decisions about care and treatment

Staff empowered patients be involved in decisions and be partners in their care.

- The provider was aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given).
- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them. Information leaflets were available in easy read formats, to help patients be involved in decisions about their care. Makaton booklets (a language programme that gives everyone assistance to speak with patients with communication difficulties) were kept in all cars and at bases.
- Patients told us through comment cards, that 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.

The service recognised the totality of people's needs. For example, patients with learning disabilities or complex

social needs, family, carers or social workers were appropriately involved. Medvivo had worked collaboratively with third sector groups to improve patient experience for those in minority groups or with a disability and to ensure their input when developing their model of care. Working with a national association for people affected by blindness had led to patient information being created in braille and some patient groups having access to care via a telephone number that bypassed the normal line.

- Parents attending the Children and Young Persons Clinic had suggested that the service stock copies of "My Hospital Passport" (a leaflet produced by the Autistic Society) to facilitate coordinated care when children with autism were moving between services. This suggestion was acted upon.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- Patients told the provider that it would be reassuring for them to have information about the service following a home visit OOH. An information card was produced which the visiting clinician left with the patient. The card enabled patients to provide feedback about the service they received but also told them the name of the clinician and how to contact the service, should they need to again. This was further improved recently by including an option to complete the feedback on line and a new 'wallet' sized card which included a QR code for easier access to the online survey. A similar feedback card was then produce for the UC@H service.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- Staff respected confidentiality at all times.
- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

The service monitored the process for seeking consent appropriately.

Outstanding ☆

Are services responsive to people's needs?

We rated the service as outstanding for providing responsive services.

Responding to and meeting people's needs

The provider organised and delivered services to meet patients' needs. Services were tailored to the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care.

- The provider used innovative ways to look at the range of services they were offering and tailored them to best meet the needs of the patients. The provider delivered an Urgent Care at Home service, which had been jointly commissioned by NHS Wiltshire Clinical Commissioning Group and Wiltshire County Council. The service ensured an integrated rapid health and social care response for service users in a health or social care crisis in their own home. The Single Point of Access (SPA) assessed and coordinated support for service users and deployed the Mobile Response Service, within one hour from receipt of referral, who actively supported patients in the short term (up to 72 hours) whilst the SPA arranged any on-going support required in order to avoid inappropriate admissions and expedite hospital discharges. The service was supporting over 250 people each month, to remain at home or to return home from hospital as soon as possible. This had not only improved patient outcomes but it has also supported the whole system in terms of delays to transfers of care, increased capacity and financial savings. This service has been published on the Kings Fund website as a best practice case study, shortlisted for the Local Government Chronicle awards and had won a Success in Partnership award from Wiltshire County Council.
- The provider engaged with commissioners to secure improvements to services where these were identified. For example, the provider worked with GP urgent care leads and clinical commissioning quality leads across the area to review and redesign case flow to ascertain which patients would benefit from an NHS Pathways assessment and which should go directly to the Clinical Assessment Service or another service. This led to the implementation of specific pathways for specific patients. For example, patients under five years of age, a cohort that can deteriorate quickly, were automatically offered an assessment with a clinician. This had expedited face to face assessment, for a patient group that can deteriorate very quickly, and prevented consultations being sought elsewhere such as emergency departments. Similar pathways for patients aged over 80 years had also been implemented.
- The provider improved services where possible in response to unmet needs. For example, bespoke templates were designed in order to capture referral information from healthcare professionals calling the service to refer palliative care patients. These were designed in partnership with the community palliative care clinical teams including representatives from each local hospice in order to be sure all patient needs were met. Palliative care patients were also given telephone access directly into the provider rather than having to go through NHS 111.
- The provider recognised the need to ensure sufficient cover for the services during periods of peak demand of the GP out of hours (OOH) cover.This had been achieved by employing and utilising paramedics to carry out a proportion of appropriate domiciliary visits on behalf of the clinical team, therefore enabling a higher number of visits to be made. Trial periods demonstrated improved patient outcomes from the increased clinical resource which had led to more efficient and effective home visits during busy periods. A decision has been made for this service to operate over Christmas, Easter and bank holidays. Paramedics had undertaken accredited training with the Royal College of Paramedics to ensure competencies for this role.
- The provider had been commissioned to deliver the GP Resilience Support programme which supplied in hours clinical triage support for GP practices that were experiencing short term staffing gaps.
- The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service. For example, frequent callers. It was recognised by the provider that many frequent callers were suffering with long term medical or social problems. Systems were in place to identify them and they had worked with the NHS 111 as part of their integrated urgent care service delivery, to support these patients and reduce the number of calls received. By working collaboratively with the local hospitals, the ambulance service, mental health teams and the patient's own GP, high intensity user plans were implemented where appropriate. There was evidence that these had made a positive impact. For example, In December 2018, 30 calls a day were being received from one patient. A high

Are services responsive to people's needs?

intensity user plan was implemented and by the third week of January only five calls had been received from this patient and none had been received in the two days prior to the inspection.
- The facilities and premises we visited during the inspection were appropriate for the services delivered.
- The service made reasonable adjustments when people found it hard to access the service. An example of this was the promotion to staff of the Streetlink Homelessness App, which as well as providing a means for homeless people to source services close to them, enabled staff to send an alert if a homeless person was seen and there was a concern for their welfare.

The service was responsive to the needs of people in vulnerable circumstances. Examples of this were:

- The provider had recognised that 1% of the population in the Bath and North East Somerset area were Chinese and a high proportion did not speak English. Links had been established with the Lantern project and meetings had taken place to inform this group how to access services.
- Relationships had been established with the Learning Disability forum in Swindon. At an event attended, the provider was able to help the audience understand how the out of hours service worked and how to access the NHS 111 service. Easy read leaflets and visual aids were used to demonstrate the hours in which each service could be contacted.
- Medvivo provided care to refugees being repatriated to the UK. Working with other agencies, refugees were met at the airport where a medical assessment was undertaken. Following transfer to their accommodation staff ensured that they were clear on how to access the services, to meet their health care needs.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- Patients were able to access care and treatment at a time to suit them. The service operated for 24 hours 7days a week.
- Patients could access the service via the NHS 111 service or by referral from a healthcare professional. Appointments at the out of hours (OOH) sites were booked by the service. The service did not see walk-in patients and a 'Walk-in' policy was in place which clearly outlined what approach should be taken when patients arrived without having first made an appointment, for example patients were told to call NHS 111 or referred onwards if they needed urgent care. All staff were aware of the policy and understood their role with regards to it, including ensuring that patient safety was a priority.
- In the case of the Success clinic in Swindon, appointments were made by the patient's own GP practice. Appointments for the Children and Young person clinic could be made directly with the clinic by patients.
- Workload was reviewed by the hour and staffing adjustments made as necessary. This modelling meant that the provider could respond to emerging trends and had resulted in an additional clinical assessment shift being added due to high level of demand on Friday evenings.
- Patients were generally seen on a first come first served basis, although the service had a system in place to facilitate prioritisation according to clinical need where more serious cases or young children could be prioritised as they arrived. The reception staff were aware of emergency criteria to use to alert the clinical staff if a patient had an urgent need. The criteria included guidance on sepsis and the symptoms that would prompt an urgent response. The receptionists informed patients about anticipated waiting times.
- Waiting times, delays and cancellations managed appropriately. Where people were waiting a long time for an assessment or treatment there were arrangements in place to manage the waiting list and to support people while they waited. For example, the Clinical Assessment Service (CAS) and the NHS 111 handlers were co-located. The provider monitored the queue of callers into NHS111 and were able to reallocate calls to the CAS if the queue became long and where appropriate to ensure patients got the most appropriate treatment in a timely manner.
- Patients with the most urgent needs had their care and treatment prioritised.
- Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

Outstanding ☆

Are services responsive to people's needs?

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately. The complainant was contacted by telephone on the day the complaint was received to discuss the concerns. The provider had found this to be very effective in de-escalating and resolving issues quickly to the complainant's satisfaction
- The complaint policy and procedures were in line with recognised guidance. Seventy two complaints were received in the last year. This included complaints received by the NHS 111 service. We reviewed a sample of these complaints and found that they were satisfactorily handled in a timely way.
- Issues were investigated across relevant providers and discussed at the weekly risk meeting. Staff were able to feedback to other parts of the patient pathway where relevant.

The provider undertook a comprehensive quarterly review of complaints to identify trends and themes. Lessons learned were shared widely throughout the organisation in the form of e-bulletins, printed newsletters and the intranet. Actions were taken to improve the quality of care received. For example, training had been undertaken to improve communication skills for patient facing staff.

Outstanding ☆

Are services well-led?

We rated the service as outstanding for leadership because the leadership governance and culture were used to drive and improve the delivery of high-quality person centred care.

Leadership capacity and capability

The service used a systematic approach to working with other organisations and wider health economy to improve care outcomes, tackle health inequalities and ensure the delivery of high quality person centred care.

- Leaders had the experience, capacity and skills to deliver the service strategy and address risks to it. They understood local health needs and worked to design services to reduce demand on other health and social care services. Arrangements were in place to mentor the newly appointed medical director who did not have previous experience in a senior leadership role. There was also a team of 3 clinical directors supporting the service. They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. Leaders had an inspired shared purpose and strived to deliver and motivate staff to succeed.
- The leadership and culture of the provider was used to drive improvements and deliver high quality person centred care. The provider worked effectively as a whole team, involved the patients and the community and other organisations to deliver the best outcomes and deliver the care within the community wherever possible.
- Senior management was accessible throughout the operational period, with an effective on-call system that staff were able to use.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

Vision and strategy

The strategy and supporting objectives were stretching, challenging and innovative, while remaining achievable.

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- The service developed its vision, values and strategy jointly with patients, staff and external partners.
- The provider valued staff engagement and staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The provider planned the service to meet the needs of the local population.
- The provider monitored progress against delivery of the strategy.
- The provider ensured that staff who worked away from the main base felt engaged in the delivery of the provider's vision and values.
- Quality improvement projects were regularly undertaken to continually improve the services offered to patients. For example, developing the skills of the responders to be able to undertake patient observations where the additional skills in assessment and communication enabled responders to escalate concerns more effectively.

Culture

The service had a culture of high-quality sustainable care.

- There was a clear leadership structure in place and staff felt supported by management. Staff we spoke to were proud of the organisation and spoke highly of the culture. We saw high levels of staff engagement and a common focus on improving the quality of patient experience.
- Skill mix within the service was continually assessed, in order to address the challenges faced by delivering an integrated urgent care (IUC) service to meet the needs of the community. For example, the development of prescribing pharmacists to conduct telephone triage for medicine related issues and the employment of paramedics to provide additional home visiting capacity during holiday periods.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.

Are services well-led?

- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. For example, Medvivo's bespoke leadership development programme and apprenticeships for responders to enable accredited qualifications. A training profile had been created for every role in line with the NHS England blueprint and a competency matrix had been developed for operational roles which gave clear pathways for staff to develop skills and competenices for team leader roles.
- All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the team. There were opportunities for professional development and evaluation of their clinical work. Clinical education events were organised for staff to attend. These were also advertised on the services website and clinicians working outside of the organisation were able to book places. Additionally, two nurses each year were supported to gain the accredited qualifications necessary to become Advanced Nurse Practitioners.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

There was a strong emphasis on the safety and well-being of all staff. In the most recent staff survey, 93% responded positively to the question, is positive action taken on health and wellbeing. The interventions initiated by the provider had led to a decrease in turnover of over 6% in the last 12 months. Examples of these were:

- A Health and Wellbeing Charter had been developed with staff which had led to, an improved working environment, including sit/stand desks, resources and signposting information on the intranet, peer to peer recognition awards, a celebrating success fund where managers are able to pay for an event to celebrate the successes of a team and incentives to encourage staff to proactively look after their own health with, for example discounted gym memberships, dental and eye care.
- Building a resilient workforce was a priority for the management team and a range of interventions had been initiated to support this. For example, Mental Health First Aiders, resilience workshops, self-awareness campaigns such as desk yoga and mindfulness, access to free counselling, well being incorporated into regular one to ones.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control. There were local leads who monitored and supported specialties such as safeguarding and led the Multi-Agency Risk Assessment Conference (MARAC) Primary Care Liaison service for the area to ensure a joined-up approach to patient care with local agencies and providers such as GPs, secondary care, the Police and social services.
- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. We looked at a number of these policies and found them to be regularly reviewed. For example, infection prevention control, consent and duty of candour.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety which included monitoring and managing risk within sub-contracted services.
- The provider had processes to manage current and future performance of the service. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. However, we found in the sample of medical records reviewed that documentation was not always in

line current best practice and guidance.Following the inspection the provider told us that actions had been taken to improve this with the relevant clincians. Leaders had oversight of MHRA alerts, incidents, and complaints. Leaders also had a good understanding of service performance against the national and local key performance indicators. Performance was regularly discussed at senior management and board level. Performance was shared with staff and the local CCG as part of contract monitoring arrangements.

- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality. For example, in relation to the use of nationally recognised assessment tools, National Early Warning Score (NEWS2) and the Paediatric Early Warning Score (PEWS) to identify those patients who were most unwell and required prioritising for treatment.
- The providers had plans in place and had trained staff for major incidents.
- The provider implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information which was reported and monitored, and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses. For example, Medvivo told us that they were not always satisfied with the performance being delivered by the NHS 111 service which was subcontracted to another provider. Actions were in place to address this, including hourly reporting to Medvivo when performance levels had fallen below set targets and reporting to Medvivo on patient safety investigations following breaches within the NHS 111 service. We saw that performance of the NHS 111 service against targets had improved at the end of quarter two compared to quarter one.
- The service used information technology systems to monitor and improve the quality of care.
- The service submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The service involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example, patient engagement events were held with patient participation groups. Leaders also collaborated with multiple providers to ensure that their views were heard and used to shape the mobilisation of the Integrated Urgent Care service.
- The provider implemented innovative approaches to gather feedback from people who use services, including from those in different equality groups such as; a feedback card designed specifically for children and meeting with the local Chinese community to improve the understanding of their needs.
- Staff were able to describe to us the systems in place to give feedback. For example, through the employee forum, via the intranet and staff survey. The most recent staff survey demonstrated that 84% of respondents were happy and engaged.
- The service was transparent, collaborative and open with stakeholders about performance. For example, we saw that the provider had made available on its website, the previous year's quality report for the service.
- We spoke with commissioners of the services who told us that the provider was transparent and easy to work with in very collaborative way and had worked hard to deliver on performance. Local GPs also responded positively to the service being provided for their patients.

Continuous improvement and innovation

Outstanding ☆

Are services well-led?

The leadership drove continuous improvement and staff innovation was recognised.

- There was a focus on continuous learning and improvement at all levels within the service. For example, the provider was keen to understand how well the newly mobilised Integrated Urgent Care service was performing and commissioned the Primary Care Foundation to review the model that had been implemented. The provider was using the findings to further improve the services being delivered for patients.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
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There were clear proactive approaches to piloting and embedding new ways of providing care and treatment Examples of this were:

- To meet the challenges faced by out of hours (OOH) services the provider had successfully bid for funding from the Pharmacy Integration Fund to pilot the development of prescribing pharmacists. This has been done in conjunction with the provider of the subcontracted NHS 111 service and two universities.
- The provider was working with the local mental health provider to design an improved pathway for patients. A project was being scoped to include mental health support to be included within the Clinical Assessment Service (CAS), with the aim to improve patient experience and reduce the need for crisis intervention.
- Following collaboration with Improved Access to Psychological Therapies (IAPT) the service was now in the position to include IAPT services within the Directory of Services, making these services available to more patients who called NHS 111.
- The provider was in the process of trialling the addition of a greater range of disciplines within the CAS, these included district nurses and paramedics.
- A project was in progress to improve patient flow from Salisbury Hospitals NHS Foundation Trust using technology. Patients were identified where part or all of their care could be met using a technological device that tracked patients on discharge. The objective of this system was to reduce the numbers of delayed discharges, facilitate fewer care visits and lead to improved patient safety.