iPrimaryCare Head Office

Inspection report

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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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

Letter from the Chief Inspector of General Practice

We rated this service as Good overall. This service was previously inspected in July 2017 under a different location registration (which has since been deregistered). We did not identify any breaches of regulation and at that time, the service was not rated. The full comprehensive report on the July 2017 inspection can be found by selecting the 'all services' link for iPrimary Care Head Office on our website at www.cqc.org.uk

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection at iPrimaryCare Head Office on 20 November 2019, as part of our inspection programme.

The service provides medical consultations via video link, through its website www.valahealth.com. Patients can request a GP consultation for assessment, diagnosis and management of non-urgent primary health care problems. Where deemed clinically appropriate, consultations also include a prescribing service. iPrimary Care Head Office is a low volume service with a clinical team currently comprising a doctor and a non-prescribing physician associate (physician associates work under the direct supervision of a doctor and carry out many similar tasks, including patient examination, diagnosis and treatment).

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, the service learned from them and improved their processes.

•The service routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.

•Quality improvement activity (such as clinical and internal audit) supported the delivery of safe and patient centred care.

•The service had developed a bespoke protocol to ensure that staff involved and treated people with compassion, kindness, dignity and respect.

•Patients could access care and treatment from the service within an appropriate timescale for their needs.

•There was a strong focus on continuous learning and improvement at all levels of the organisation.

We saw one area of outstanding practice:

•The service had created a set of online, induction training videos for new clinicians and which aimed to provide detail and context to areas such as video consultations, online prescribing and managing online emergencies. Leaders spoke positively about how the videos were part of a range of activities aimed at strengthening clinical governance, in advance of a service upscaling programme.

The areas where the provider should make improvements are:

•Take action to ensure a written policy is in place regarding patients' consent to share information.

•Take action to implement a prescription monitoring protocol, monitoring against any form of abuse such as excessive prescription requests.

Dr Rosie Benneyworth BM BS 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 a specialist adviser, a member of the CQC medicines team and a second inspector.

Background to iPrimaryCare Head Office

iPrimary Care Limited provides online video based consultations which can include the issuing of private prescriptions. On the day of our inspection, the clinical team consisted of a male doctor and a female physician associate (physician associates work under the direct supervision of a doctor and carry out many similar tasks, including patient examination, diagnosis and treatment).

The physician associate was also the operations manager for the service and an outsourced IT team provided technical support.

The provider offers consultations to individuals or to businesses which can opt to provide their employees with an annual budget to use in a way that best suits their needs and the business. For example, the service currently provides bespoke medical advice to a company arranging overseas expeditions. The majority of iPrimary Care Limited's patients are on individual contracts who can opt for a one off consultation or sign up to a monthly or annual plan. The provider does not have clinical premises where patients can visit.

Consultations are available between 7:00am and 7:00pm Monday to Friday and 7:00am to 12:00pm at weekends (subject to availability) but access via the website to request a consultation is available 24/7. Services are provided to children however we were told that any patients under the age of 18 years would need a parent or legal guardian to request a consultation and set up the user specific remote access. This access is then password protected to prevent unauthorised use. All initial GP consultations are carried out by video link, however subsequent consultations can be made by telephone. A protocol was in place to verify identity whereby patients presented their photographic ID to the camera.

How we inspected this service

Before the inspection we gathered and reviewed information from the provider. During this inspection we spoke to the Registered Manager and a member of the management team.

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

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

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

iPrimary Care Limited is registered for the following Regulated Activities: Transport services, triage and medical advice provided remotely and Treatment of disease, disorder or injury.

Good

Are services safe?

We rated safe as Good:

•The service had good systems to manage risk so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes.

•Staff had received up-to-date training in systems, processes and practices.

Keeping people safe and safeguarded from abuse

Staff had received training in safeguarding and whistleblowing and knew the signs of abuse. All staff had access to the safeguarding policies and where to report a safeguarding concern (for example, via a hyperlink to the safeguarding team of the local authority where the service was based). The GP had received adult and level three child safeguarding training. It was a requirement for GPs registering with the service to provide evidence of up to date safeguarding training certification. The physician associate had received level two children & young people safeguarding training and level three vulnerable adults safeguarding training.

We were advised that only adults over the age of 18 could register for an account. Registered adults could register other dependents on their account. Children would always be registered as a dependent under an adult's account and there were additional protocols in place to ensure that a child could not subsequently directly book their own appointment.

Monitoring health & safety and responding to risks

The provider's headquarters was located within modern offices which housed the IT system and a range of outsourced IT support staff. Patients were not treated on the premises as clinicians carried out the online consultations remotely from the office.

Systems were in place to ensure clinicians conducted consultations in private and maintained patient confidentiality. For example, they used an encrypted, password secure laptop to log on to the provider's operating system and we also noted the video consultation room was sound proofed.

There were processes in place to manage any emerging medical issues during a consultation and for managing test results and referrals. The service was not intended for use by patients with either long term conditions or as an emergency service. In the event an emergency did occur, the provider had systems in place to ensure the location of the patient at the beginning of the consultation was known, so emergency services could be called.

Minutes of regularly held clinical meetings confirmed that matters such as significant events analyses, clinical audit results, safety issues and technical issues were routinely discussed.

If a telephone consultation was booked, clinicians dialled out at the appropriate time, therefore addressing any concerns about caller withheld numbers.

Staffing and Recruitment

We noted the low volume nature of the service and were assured there were enough staff to meet demand. The provider had a selection and recruitment process in place for all staff. There were a number of checks that were required to be undertaken prior to commencing employment, such as references and Disclosure and Barring service (DBS) checks. 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.

Potential GP employees had to be currently working in the NHS and be registered with the General Medical Council (GMC) with a license to practice. They had to provide evidence of having professional indemnity cover (to include cover for video consultations), an up to date appraisal and certificates relating to their qualification and training in safeguarding and the Mental Capacity Act.

Systems were in place to ensure that newly recruited GPs were supported during their induction period and an induction plan was in place to ensure all processes were covered. We were told that a new GP would not start consulting with patients until they had successfully completed several test scenario consultations.

We noted the service had created a set of online, induction training videos for new clinicians and which aimed to provide detail and context to areas such as video consultations, online prescribing and managing online emergencies. Leaders spoke positively about how the videos were part of a range of activities aimed at strengthening clinical governance, in advance of a service upscaling programme.

Good

Are services safe?

The provider kept records for staff and there was a system in place that flagged up when any documentation was due for renewal such as their professional registration. We reviewed the two clinician's recruitment files and confirmed these contained the necessary documentation.

Prescribing safety

All medicines prescribed to patients by video consultation were monitored by the provider to ensure prescribing was evidence based. If a medicine was deemed necessary following a video consultation, the GP could issue a private prescription to the patient.

The GP could only prescribe from a set list of medicines which the provider had risk-assessed. There were no controlled drugs (CDs) on this list. The provider told us they had prescribed CDs on two occasions in the past 12 months to patients known to the service but that as part of strengthening clinical governance, this practice had since ceased. The physician associate did not prescribe medication.

Once the GP prescribed the medicine and dosage of choice, relevant instructions were given to the patient regarding when and how to take the medicine, the purpose of the medicine, any likely side effects and what they should do if they became unwell.

The service did not generally repeat prescribe for patients with long term conditions who would need to be monitored. The service's website advised that short-term prescriptions for maintenance medicines may be obtained but that this was on a case by case basis and usually no more than one week's supply would be prescribed. We saw one instance of where this had happened in the previous 12 months but noted the absence of a written protocol governing how this should be documented.

The service encouraged good antimicrobial stewardship and kept an antibiotic formulary (based on national guidance) for different types of antibacterial infections. We saw evidence that audits had been undertaken to ensure that antimicrobial usage was in accordance with NICE guidelines.

The service prescribed some unlicensed medicines, and medicines for unlicensed indications, for example for the treatment of jet lag. Medicines are given licences after trials have shown they are safe and effective for treating a particular condition. Use of a medicine for a different medical condition that is listed on their licence is called unlicensed use and is a higher risk because less information is available about the benefits and potential risks.

We were told that where unlicensed medicines were prescribed, patients were verbally advised the medicines were being used outside of their licence and this was recorded in consultation notes. We were further advised that additional written information to guide the patient when and how to use these medicines safely was supplied with the medicine.

There were protocols in place for identifying and verifying the patient and General Medical Council guidance, or similar, was followed.

We were advised that patients could choose a pharmacy where they would like their prescription dispensed. The prescription could be dispensed and delivered direct to the patient or to their preferred local pharmacy for collection by the patient. The service had a system in place to assure themselves of the quality of the dispensing process.

We did not see evidence of a prescription monitoring protocol in place to monitor against any form of abuse such as excessive requests. We were told that this was because the service did not generally repeat prescribe for chronic conditions and had ceased prescribing Controlled Drugs. However, the provider told us that such a protocol would be introduced in advance of a service upscaling programme.

We noted that the service was contracted to provide prescription only medicines for overseas expeditions' medical kits. The provider's GP would carry out a video consultation with people going on an expedition and write a private prescription. The prescription was sent to a UK based pharmacy and the medicines sent to the expedition company and inserted into the medical kits. We were advised the provider sent additional advice to the expedition medic in the form of a handbook and instructions detailing indications, side effects, contra-indications and dosing regimes. If medicines were administered during the expedition, this was relayed to the provider who would make a record of administration into the patient's record. Any follow up that was needed on return from the expedition was assessed by the provider's GP.

Good

Are services safe?

Information to deliver safe care and treatment

On registering with the service, and at each consultation patient identity was verified. The GP had access to the patient's previous records held by the service.

Management and learning from safety incidents and alerts

There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. We reviewed one incident from five recorded in the previous 12 months and found these had been fully investigated, discussed and as a result action taken in the form of a change in processes.

For example, protocols had been strengthened following an incident whereby a patient had attempted to seek medical advice outside the normal consultation booking process. We noted learning from such incidents was discussed at minuted quarterly staff meetings.

When we spoke with the clinicians they demonstrated an understanding of the requirements of the duty of candour if things went wrong. For example, by explaining to the patient what went wrong, offering an apology and advising them of any action taken.

There were systems in place to receive and act on safety alerts as necessary.

Good

Are services effective?

We rated effective as Good:

•The service routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.

•Quality improvement activity (such as clinical and internal audit) supported the delivery of safe and patient centred care.

Assessment and treatment

We reviewed five examples of medical records that demonstrated that the GP assessed patients' needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) evidence based practice.

For example, the records we reviewed highlighted a very low risk prescribing pattern and we did not see any evidence of deviation from evidence based medicine. We were told that patients were appropriately informed when unlicensed or off label medicines were used (for example, the use of a medicine for a different medical condition than that for which it is licensed and therefore carrying a higher risk because less information is available about the benefits and potential risks).

We were told that each online consultation lasted for 30 minutes. If the GP had not reached a satisfactory conclusion there was a system in place where they could contact the patient again and we noted that all consultations were routinely followed up with an email. Patients were not charged for any immediate follow up consultation.

Patients completed an online form which included their past medical history (for example current medication and known allergies). There was a set template to complete for the consultation that included the reasons for the consultation and the outcome, to be manually recorded along with any notes about past medical history and diagnosis. We reviewed five medical records which were complete records. We saw that adequate notes were recorded and the GPs had access to all previous notes.

The GP leading the service was aware of both the strengths (speed, convenience, choice of time) and the limitations (inability to perform physical examination) of working remotely from patients. They worked carefully to maximise the benefits and minimise the risks for patients. If a patient needed further examination they were directed to an appropriate agency.

We noted a range of clinical tool templates available to clinicians to assist clinical assessment regarding, for example, travel health, sexual health and feverish children. If the provider could not deal with the patient's request, this was explained to the patient and a record kept of the decision.

Quality improvement

The service collected and monitored information on patients' care and treatment outcomes.

•The service took part in quality improvement activity, for example audits of consultations and patient identity checks.

•The service also carried out clinical audits to improve patient outcomes and we saw, for example, evidence of a structured audit programme including antibiotic prescribing, contraceptive prescribing and off-label medications. Leaders told us they were considering appointing a clinical director to provide clinical oversight of its clinical audit programme.

•In 2017, the service also commenced regular audits of Controlled Drugs prescribing which triggered a protocol review and in 2018 culminated in the service ceasing to prescribe Controlled Drugs.

Staff training

All clinical staff completed induction training which included video consultations, online emergencies, confidentiality, online prescribing (for doctors) and referrals. Staff also completed other training on a regular basis such as safeguarding. A regularly updated training matrix identified when training was due.

Supporting material such as clinical tools, how the IT system worked and aims of the consultation process were also available. Clinicians told us they received excellent support if there were any technical issues and that if any updates were made to the IT systems, they received further online training.

GPs had to have received their own appraisals before being considered eligible at recruitment stage.

Coordinating patient care and information sharing

Good

Are services effective?

Before providing treatment, clinicians ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history. We saw examples of patients being signposted to more suitable sources of treatment where this information was not available to ensure safe care and treatment.

Two of the five records we reviewed had not recorded patients' GP details and one of these had additionally failed to record the patient's consent to share details of their consultation with their registered GP. We also noted the absence of a formal policy in relation to patient consent to share information. Where patients had agreed to share their information, records confirmed that the letters sent to their registered GP were in line with GMC guidance. Leaders told us they were considering appointing a clinical director to provide clinical oversight in areas such as internal auditing of consultation notes.

The provider had risk assessed the treatments they offered. They had identified medicines that were not suitable for prescribing if the patient did not give their consent to share information with their GP, if they were not registered with a GP or if a full patient history was not provided. For example, medicines liable to abuse or misuse, and those for the treatment of long term conditions such as asthma.

We asked how referrals and test results were processed and were advised that clinicians entered referral information onto the service's computer system (including where the patient wanted to attend). This information was then used to generate a referral letter which was sent to the patient and their NHS GP.

Supporting patients to live healthier lives

The service addressed the needs of patients who may be in need of extra support. Following a consultation, the patient was sent a consultation summary which included healthy living advice (for example smoking cessation, dietary advice and links to NHS websites). This was available on line on the patient's consultation "timeline" and could be reviewed by the patient at any time.

Good

Are services caring?

We rated caring as Good:

•Staff were highly motivated and had developed a bespoke protocol to ensure staff were compassionate and promoted people's dignity. Patient survey feedback was positive regarding staff attitudes.

•People's privacy and confidentiality was respected at all times.

Compassion, dignity and respect

We saw that clinicians primarily undertook video consultations in a private, sound proofed room in the service's main office. A number of checks were in place to ensure patients' privacy and dignity were respected including: confirming the patient's name, positioning the laptop so that other people could not see the consultation screen and ensuring the patient was in a private room.

In advance of a service upscaling programme, the service had recently adopted a patient experience protocol called CICARE (Connect, Introduce, Communicate, Ask, Respond, Exit) which aimed to ensure an exceptional patient experience by bringing more intention, focus and compassion to patient interactions.

Leaders spoke positively about how the approach recognised that each on line patient interaction was different and that consequently, the service needed to be patient centred in its vision, values and behaviour.

We did not speak with patients directly on the day of the inspection. However, we reviewed the latest annual survey information (2018) undertaken by the provider. At the end of every consultation, patients had been sent an email asking for their feedback and we noted that all eight patients surveyed indicated they were very satisfied and had been provided with accurate information.

Involvement in decisions about care and treatment

Patient information guides about how to use the service and resolve technical issues were available. There was a dedicated team to respond to any enquiries.

Patients had access to information about the clinicians working for the service and could book a consultation with a male GP or female physician associate of their choice. Clinicians spoke a variety of languages.

The latest survey information available indicated that all eight patients felt they were provided with accurate information and felt involved in decisions about care and treatment.

Good

Are services responsive to people's needs?

We rated responsive as Good:

•Patients could access care and treatment from the service within an appropriate timescale for their needs.

•Systems were in place to ensure improvements were made to the quality of care as a result of complaints and concerns.

Responding to and meeting patients' needs

The provider offered on line video consultation services to individuals or to businesses (which could opt to provide their employees with an annual budget to use in a way that best suited their needs and the business). The provider did not offer a clinical premises where patients could visit.

Consultations were available between 7:00am and 7:00pm Monday to Friday and 7:00am to 12:00pm at weekends (subject to availability) but access via the website to request a consultation was available 24/7. Services were provided to children however we were told that any patients under the age of 18 years would need a parent or legal guardian to request a consultation and set up the user specific remote access. This access was then password protected to prevent unauthorised use. All initial consultations were carried out by video link, however subsequent consultations could be made by telephone.

The provider made it clear to patients what the limitations of the service were (for example highlighting on its website that the service was not an emergency service).

The digital application allowed people to contact the service from abroad but all medical practitioners were required to be based within the United Kingdom.

Patients requested an online consultation with a GP or physician associate and were contacted at the allotted time. The maximum length of time for a consultation was 30 minutes. If the GP had not reached a satisfactory conclusion there was a system in place where they could contact the patient again.

Tackling inequity and promoting equality

The provider offered consultations to anyone who requested and paid the appropriate fee, and did not discriminate against any client group.

Patients could access a brief description of the two clinicians available and had a choice of either a male GP or female physician associate. Instant text messaging was also available to complement the service's video consultation facility and assist patients with impaired hearing.

Managing complaints

Information about how to make a complaint was available on the service's web site. The provider had developed a complaints policy and procedure. The policy contained appropriate timescales for dealing with the complaint. There was escalation guidance within the policy. A specific form for the recording of complaints has been developed and introduced for use. The service had not received any complaints in the previous 12 months but we noted systems were in place to ensure improvements could be made to the quality of care as a result of complaints and concerns. For example, team meeting minutes highlighted that complaints management was listed as a standing agenda item.

Consent to care and treatment

There was clear information on the service's website with regards to how the service worked and what costs applied including a set of frequently asked questions for further supporting information.

For example, the website noted that the provider offered services to individuals or to businesses and that individuals could opt for a one off consultation or sign up to a monthly or annual plan.

The website further noted that the prescription; cost of medications and their delivery was not included in the price of a consultation, monthly or annual plan and that the price would depend on the medication and the speed of delivery required.

The two clinicians had received training about the Mental Capacity Act 2005. They understood and sought patients' consent to care and treatment in line with legislation and guidance. When providing care and treatment for children and young people, they 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 they assessed the patient's capacity and, recorded the outcome of the assessment.

Good

Are services well-led?

We rated well-led as Good:

•There was a strong focus on continuous learning and improvement at all levels of the organisation.

•There was an effective governance framework in place, focussing on delivering good quality care and which had been further strengthened in advance of a service upscaling programme.

Business Strategy and Governance arrangements

Leaders told us they had a clear vision to work together to provide high quality and patient-focused care. There was a clear organisational structure and leaders were aware of their own roles and responsibilities. There was a range of service specific policies which were available. These were reviewed annually and updated when necessary.

There were a variety of regular checks in place to monitor the performance of the service. For example, audits of records and prescribing patterns. Regular minuted clinical governance meetings took place where audit findings were reviewed in addition to safety issues, medical records issues, new protocols and technical issues. This ensured a comprehensive understanding of the performance of the service was maintained.

There were also arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Care and treatment records were generally complete, accurate, and securely kept but we did note that three consultation notes did not log GP details and/or patient consent to share information.

Leadership, values and culture

The GP was also Medical Director and had responsibility for any medical issues arising and attended the service daily. There were systems in place to address any absence of this clinician and we were told that the service was considering appointing a part time Clinical Director to provide clinical oversight (for example leading on internal and clinical audit).

We were told the values of the service were accessibility, innovation, effectiveness and trust.

The service had an open and transparent culture. We were told that if there were unexpected or unintended safety incidents, the service would give affected patients reasonable support, truthful information and a verbal and written apology. This was supported by an operational policy which was accessible by all staff.

Safety and Security of Patient Information

Systems were in place to ensure that all patient information was stored and kept confidential.

There were policies and IT systems in place to protect the storage and use of all patient information. The service could provide a clear audit trail of who had access to records and from where and when. The service was registered with the Information Commissioner's Office. There were business contingency plans in place to minimise the risk of losing patient data.

Seeking and acting on feedback from patients and staff

Patients were emailed at the end of each consultation with a link to a survey they could complete. The survey included questions on overall patient satisfaction, providing accurate information; and dignity and respect. Patients could also post any comments or suggestions online.

The provider had a whistleblowing policy in place (a whistle blower is someone who can raise concerns about practice or staff within the organisation). The GP was the named person for dealing with any issues raised under whistleblowing.

Continuous Improvement

The service consistently sought ways to improve. All staff were involved in discussions about how to run and develop the service, and were encouraged to identify opportunities to improve the service delivered.

Although a written quality improvement strategy was not in place, the service regularly monitored quality and sought to make improvements (for example, through internal and clinical audit; and participation in various sector led quality improvement fora).

Records confirmed that regular, minuted team meetings took place, where staff could raise concerns and discuss areas of improvement. Also, as clinicians and the outsourced IT team worked in the same building, they routinely discussed technical service provision and improvements.

Good

Are services well-led?

As part of continuous improvement, the service had also recently adopted a new patient experience protocol and was considering appointing a clinical director to strengthen clinical governance arrangements, in advance of a service upscaling programme.