ZoomDoc Ltd

ZoomDoc Base

Inspection report

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Date of inspection visit: 28 February 2018
Date of publication: 25/04/2018

Overall summary

We carried out an announced comprehensive inspection at ZoomDoc Base on 28 February 2018 as part of our inspection programme.

ZoomDoc Base is a mobile application (app) based private GP visiting service which provides telephone and face-to-face GP consultations at the patient's home, office or hotel. Patients are able to book a 10 minute telephone or 25 minute face-to-face consultation with a GP 24 hours a day and seven days a week.

We found this service provided responsive, caring and well-led services in accordance with the relevant regulations. However, service was not providing safe and effective services in some areas in accordance with the relevant regulations.

Our findings in relation to the key questions were as follows:

Are services safe? - We found the service was not providing a safe service in some areas in accordance with the relevant regulations.

- The provider did not ensure proper and safe management of medicines including the doctors' bag.
- The protocol for prescribing did not include the clear guidance for visiting GPs regarding the safe prescribing of off-licence medicines and some other medicines.
- Infection control audits had not been carried out.
- Arrangements were in place to check evidence of parental responsibility where an adult was consenting to treatment on behalf of a child, but this was not documented in the child notes after consultations.
- Arrangements were in place to safeguard people, including arrangements to check patient identity during face-to-face consultations.
- There were enough GPs to meet the demands on the service.

Are services effective? - We found the service was not providing an effective service in some areas in accordance with the relevant regulations.

- There was some evidence of quality improvement activity.
- The provider had not provided clear clinical evidence based guidance to prescribe longer prescriptions of benzodiazepines, the oral contraceptive pill and hormone replacement therapy which could lead to large quantities being prescribed without further investigation.
- All GPs had attended role-specific training in safeguarding of vulnerable adults, safeguarding children level three and basic life support. However, the provider was unable to provide evidence that all GPs had received formal training in infection control, health and safety, information governance and the Mental Capacity Act.

Summary of findings

- Following patient consultations information was appropriately shared with a patient's own GP in line with GMC guidance.

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

- The provider carried out checks to ensure consultations by GPs met the expected service standards.
- Patient feedback reflected they found the service treated them with dignity and respect.
- Patients had access to information about GPs working at the service.

Are services responsive? - We found the service was providing a responsive service in accordance with the relevant regulations.

- Information about how to access the service was clear and the service was available 24 hours a day and seven days a week.
- The provider did not discriminate against any client group.
- Information about how to complain was available and complaints were handled appropriately.

Are services well-led? - We found the service was providing a well-led service in accordance with the relevant regulations.

- The service had clear leadership, a business strategy and plans to grow and expand the service.
- There was a clear ethos of patient centred care.
- There were clinical governance systems and processes in place to monitor and improve the quality and performance of the service. However, the provider did not have a monitoring procedure in place to ensure the safety and effectiveness of the doctors bag.
- Service specific policies were available with the exception of a whistleblowing policy.
- The service encouraged and acted on feedback from both patients and staff.
- Systems were in place to protect personal information about patients. The company was registered with the Information Commissioner's Office.

We identified regulations that were not being met and the provider must:

- Ensure care and treatment is provided in a safe way to patients.

The areas where the provider should make improvements are:

- Ensure that where a consultation is held with a child, GPs document that they have seen evidence of parental responsibility in the notes.
- Implement the recruitment policy in place to ensure two staff references are always collected.
- Implement quality improvement initiatives which may include completed clinical and prescribing audits.
- Ensure all staff receives the appropriate training necessary to enable them to carry out their duties.
- Consider arranging a translation service and review the information available for patients who do not speak English.
- Develop a whistleblowing policy.

You can see full details of the regulations not being met at the end of this report.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Are services effective?

Are services caring?

Are services responsive to people's needs?

Are services well-led?

ZoomDoc Base

Detailed findings

Background to this inspection

ZoomDoc Ltd provides a private, non NHS service. The service started in March 2017. The service does not employ any staff and all 16 GPs are self-employed. All GPs are UK based, on the General Medical Council (GMC) register, working in the NHS and have an indemnity insurance to cover their work.

ZoomDoc Base is a mobile application (app) based on-demand GP visiting service which offers medical advice and treatment within patients' own homes, office or hotel. The app has been downloaded over 4800 times and the service has carried out 555 consultations. There are 2,970 patients registered with the service. To be eligible to register for a ZoomDoc account the patient must be 18 years of age or older. Parents or legal guardians may add children below the age of 18 years of age to their primary ZoomDoc account as patients after initial registration.

Patients are able to book appointments at a time to suit them and with a doctor of their choice via an online app. Patients are able to book a 10 minute telephone or 25 minute face-to-face consultation with a GP 24 hours a day and seven days a week. Telephone consultation is offered nationwide and face-to-face consultation is offered in and around London area. GPs, working remotely, conduct consultations with patients and, where appropriate, issue prescriptions (only after face to face consultations) or make referrals to specialists; consultation notes are available for patients to access. Patients must pay for an individual consultation by credit or debit card only via the ZoomDoc app.

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

The service is registered with the Care Quality Commission for the regulated activities of Treatment of disease, disorder or injury and Transport services, triage and medical advice provided remotely.

Are services safe?

Our findings

We found that this service was not providing safe care in some areas in accordance with the relevant regulations.

Keeping people safe and safeguarded from abuse

All GPs at the service had received training in safeguarding and knew the signs of abuse. All staff had access to the safeguarding policies and where to report a safeguarding concern. All the GPs had received adult and level three child safeguarding training. It was a requirement for the GPs registering with the service to provide evidence of up to date safeguarding training certification.

The service treated children and had a system in place to ensure that children were protected.

Registered account holders could set-up profiles for children aged under 18, which could be viewed by the main account holder only. The service had processes in place to ensure that those who set up accounts for children had parental responsibility for them, and their policy on access to the records of patients aged 11-18 was in line with national guidance. The service had a policy in place which required evidence of parental responsibility to be provided before a child could be seen by the visiting on-call doctor. However, we noted the doctor did not document in the child notes that they had seen the evidence of parental responsibility.

Monitoring health & safety and responding to risks

The lead GP worked from a home office and the service did not employ any staff. All doctors were self-employed and had to pass through the provider's registration and vetting process before they were given access to the provider's secure operating system. Patients were not treated on the premises, as GPs carried out the telephone consultations remotely; usually from their home. Patients were treated by visiting on-call GPs at their homes, offices and hotels.

The provider expected that all GPs would conduct consultations in private and maintain the patient's confidentiality. All GPs had been made aware of the provider's confidentiality policy as part of their induction, and they had signed an online confidentiality agreement during their registration process.

There was a clear desk and screen policy, computer and data security procedure, and email and internet usage policy to ensure the security of sensitive personal data. Each GP used an encrypted, password protected smart mobile telephone which required fingerprint recognition to log into the operating system (online app), which was a secure programme. Each GP was able to access the online doctor portal through the provider's website which was password protected and required verification code to access the service.

The online app had a system failure protocol to ensure the continuity of service. The provider had full and accessible data backups so that in the event of any system failure, data could be restored so that normal operations could be resumed quickly and effectively.

There were processes in place to manage any emerging medical issues during a consultation and for managing referrals. The service provided referral letters for private hospitals or private consultants if required.

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 service 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.

The provider made it clear to patients what the limitations of the service were. The provider informed patients they were unable to prescribe high risk medicines, including morphine based medicines, strong sleeping tablets or medicines that would normally be prescribed (or require close monitoring) by a specialist.

Clinical consultations were rated by the GPs for risk. However, the prescribing doctor could discuss patients with the provider's clinical lead when necessary and processes were in place in relation to assessing and escalating risk.

Quarterly virtual clinical meetings were held with GPs, where standing agenda items covered topics such as significant events, complaints and service issues. Clinical meetings also included case reviews and clinical updates. We saw evidence of meeting minutes to show where some of these topics had been discussed.

There was a health and safety policy, fire safety policy, needle stick injury protocol, handwashing protocol and infection control policy. However, infection control audits had not been carried out.

Are services safe?

On the day of the inspection, the provider was unable to provide evidence that all GPs had received training in health and safety and infection control. The service was not following their own infection control policy which required all staff to undertake infection control training.

Staffing and Recruitment

There were enough GPs, to meet the demands of the service and there was a rota for the GPs. There was a clinical lead available to the GPs during consultations and a separate IT team. The prescribing doctors were paid on a per consultation basis.

The provider had a selection and recruitment process in place for all GPs. 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.)

All GPs were self-employed. The provider had a requirement that participating GPs must be currently working in the NHS as a GP and be registered with the General Medical Council (GMC) on the GP register. They had to provide evidence of having professional indemnity cover (to include cover for telephone, out of hours and call-out consultations), an up to date NHS appraisal and certificates relating to their qualification and training in safeguarding and basic life support.

Newly recruited GPs were supported during their induction period and an induction plan was in place to ensure all processes had been covered. We were told that GPs did not start consulting with patients until they had attended a face to face session with a clinical lead and successfully met the relevant criteria.

We reviewed three recruitment records which showed most of the necessary documentation was available. The GPs could not be registered to start any consultations until these checks and induction training had been completed. The provider kept records for all the GPs and there was a system in place to monitor and follow up when any documentation was due for renewal such as their professional registration. However, the provider was not completely following their own recruitment policy regarding the collection of two references. Out of three recruitment records we checked the provider had collected one reference for each GP.

Prescribing safety

According to the provider's protocol for prescribing:

- The GPs could only prescribe from a set list of medicines which the provider had risk-assessed.
- There were no controlled drugs on this list or any high risk medicines which required regular monitoring. The service's website made this information clear to patients.
- All medicines were prescribed based on clinical need on an acute basis.
- The service encouraged good antimicrobial stewardship by only prescribing from a limited list of antibiotics which was based on national guidance.
- 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 and any likely side effects and what they should do if they became unwell.
- The provider did not have a repeat prescribing policy and patients were advised to contact their regular GP.
- The private prescriptions were written on letter headed paper, which included a company name, logo and other necessary information. These paper prescriptions were prescribed and signed by the visiting GP with their GMC number and company contact number.
- The private prescriptions could be processed electronically via eFax. It was the doctor's responsibility to liaise with the local pharmacy to ensure receipt of the faxed prescription and also to post the original prescription to the pharmacy within 72 hours. All visiting on-call GPs had access to a list of local pharmacies developed by the provider. Patients were able to choose a pharmacy where they would like to collect their prescription from.
- All medicines prescribed to patients during a consultation were monitored by the provider to ensure prescribing was evidence based.
- The private prescriptions were only issued by the visiting on-call doctor after face to face consultation or provide

the medicines from the doctors bag. However, the doctors bag did not include some medicines which could be required to treat acute conditions during the call out visits.

The doctors bag included the Glucagon (injection used to treat low blood sugar level). However, the provider's medicines policy did not include the safe storage guidelines for Glucagon, which is affected by exposure to very hot or cold temperatures.

Each GP was responsible for managing the contents of doctors bag, including stock control and monitoring the expiry dates of medicines. However, the provider did not have a monitoring procedure in place to assure themselves that required actions had been taken to ensure the safety of doctors bag.

According to the provider's protocol for prescribing the visiting GPs would not prescribe medicines for more than two months. However, it included following exceptions that the visiting GP at their discretion:

- could prescribe longer prescriptions of benzodiazepines (medicines used to treat symptoms of anxiety, panic attacks, insomnia and muscle spasms). It was included in the protocol that the reason for this should be clearly documented in the notes. However, the provider had not provided clear guidelines to the visiting GPs in their prescribing protocol which could lead to large quantities being prescribed without further investigation.
- could prescribe the oral contraceptive pill and hormone replacement therapy up to six months. This was not in line with National Institute for Health and Care Excellence (NICE) guidelines which recommended prescribing up to three months if a new prescription and monitoring the blood pressure before a repeat prescription was issued.

According to the provider's protocol for prescribing, the visiting GPs could prescribe off licence medicines if required, and that they should be discussed with the patients and recorded in the patients' record. (Treating patients with off licence medicines is higher risk than treating patients with licensed medicines, because off licence medicines may not have been assessed for safety, quality and efficacy for a condition not included in the licence. The Medicine and Healthcare products Regulatory Agency (MHRA) guidance states that off licence medicines may only be supplied against valid special clinical needs of an individual patient. The General Medical Council's prescribing guidance specifies that off licence medicines may be necessary where there is no suitable licensed medicine). The provider's protocol for prescribing did not include any information for the visiting GPs to guide when and which off licence medicines they could prescribe.

Additional written information was not available to be supplied with the medicine to guide the patient when and how to use off licence medicines safely, and that the patient had to acknowledge that they understood this information. The provider informed us they had not prescribed any off licence medicine since the launch of the service.

Information to deliver safe care and treatment

- On registration there were protocols in place verifying patient identity through their mobile telephone number and email address.
- The provider had a policy to verify the account holder mobile telephone number which was registered during the registration process before a telephone consultation could be started.
- Patients could also register themselves and their children directly with the service. In this case, identity checking would be conducted using the patient's payment card details. The provider informed us they were planning to install a new online identity verification system within four months.
- At each face to face consultation patients confirmed their identity by producing their passport or driving licence. Patients were informed during the registration and appointment booking process that the consultation would be declined if they failed to confirm their identity or evidence of parental responsibility (where the patient being seen was a child) before the start of face to face consultation.
- Individual care records were written and managed in a way that kept patients safe. Patient records were stored securely using an electronic record system.
- The GPs had access to the patient's previous records held by the service. The GPs used their doctors app or doctor portal via their laptop to log into the operating system, which was a secure programme.
- The service was registered with the Information Commissioner's Office.

Are services safe?

- The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- Risks related to patients' diagnoses and other health and wellbeing risks were recorded in patients' records.

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. However, we could not assess its effectiveness as no incidents had been reported.
- The registered manager demonstrated an understanding of which incidents were notifiable under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- The provider had signed up to receive patient and medicine safety alerts. The registered manager provided examples of alerts they had received but there were no examples of alerts being acted on as none had been relevant.

Are services effective?

(for example, treatment is effective)

Our findings

We found that this service was not providing effective service in some areas in accordance with the relevant regulations.

Assessment and treatment

We reviewed six examples of medical records that demonstrated that each GP assessed patients' needs and delivered care in line with relevant and current evidence based guidance and standards. However, the provider had not provided clear clinical evidence based guidance to prescribe longer prescriptions of benzodiazepines, the oral contraceptive pill and hormone replacement therapy which could lead to large quantities being prescribed without further investigation.

When patients registered for the service they completed a personal profile which included information about their past medical history, personal details, date of birth, drug allergies and NHS GP details (plus consent to update NHS GP of all consultations details).

The service offered telephone and face to face consultations.

We were told that each telephone consultation lasted for 10 minutes and each face to face consultation lasted for 25 minutes. If the GP had not reached a satisfactory conclusion there was a system in place where they could charge an additional fee for every additional five minutes.

Before visiting a patient for a face to face consultation, the on-call GP would call to carry out a pre-visit assessment by telephone and this information was used as part of the triage process to ensure the service was suitable to meet the clinical needs of the patient.

There was a set template to complete to record details of the consultation that included the reasons for the consultation and the outcome, along with any notes about past medical history and diagnosis. We reviewed six medical records which were complete records. We saw that adequate notes were recorded and the GPs had access to all previous notes. However, two out of six medical records had limited past medical history recorded.

The GPs providing the visiting service were aware of both the strengths (speed, convenience, choice of time) and the limitations (inability to perform physical intimate examination due to non-availability of a chaperone) of working as visiting GPs. 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. 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 took part in some quality improvement activity.

- The service had offered 555 consultations (75% face to face and 25% telephone only consultations) since it started in March 2017.
- The service monitored consultations, prescriptions and the diagnosis process. The service carried out reviews of consultations to monitor appropriateness of the care provided and improve patient outcomes. A sample of consultations was reviewed as part of GPs' regular performance reviews.
- The service used information about both patients' outcomes and patient feedback to make improvements.
- There were no prescribing audits to monitor the individual prescribing decisions, for example, to monitor their antibiotic prescribing, but individual patients on prescribed medicines were monitored to identify the appropriateness of their medicines. Overall clinical outcomes for patients were monitored.
- The clinical lead GP had plans to carry out individual prescribing audits to improve patient outcomes; this was not in place at the time of our inspection but we saw they had developed an audit policy with an outline programme for 2018.

Staff training

The GPs registered with the service had to receive specific induction training prior to treating patients. An induction log was held in each staff file and signed off when completed. All GPs had to complete video training to enable them to operate app based software. Supporting protocols were available as guidance on computer and data security procedures, information about how the IT system worked, and information about accessing patient records and the clinical notes recording process. The GPs we spoke with told us they received excellent support if there were any technical issues or clinical queries and could access policies. When updates were made to the IT systems, the GPs received further online training.

Are services effective?

(for example, treatment is effective)

All GPs had attended most role-specific training and the provider had a monitoring system in place which identified when training was due. The provider had decided to monitor training only in three areas that included: safeguarding of vulnerable adults, safeguarding children level three and basic life support. However, the provider was not following their own training policy which required basic life support training to be completed every year. Of the staff training records we saw, we noted that one of the GPs had last attended basic life support training on 2 November 2016.

On the day of the inspection, the provider was unable to provide evidence that all GPs had received formal training in infection control, health and safety, information governance and the Mental Capacity Act. However, the provider had written policies and protocols available which consisted of the relevant information and all GPs were able to access these via the provider's app or doctors portal.

All GPs received regular performance reviews as and when required but details were not documented. All the GPs had to have received their own NHS appraisals before being considered eligible at recruitment stage. The provider informed us that they would ensure all GPs had received in-house annual appraisals from March 2018 onwards, which would be documented. The service was launched in March 2017 which meant that in-house annual appraisals were not due at the time of the inspection.

Coordinating patient care and information sharing

When a patient contacted the service they were asked if the details of their consultation could be shared with their NHS GP. If the patient did not agree to the service sharing information with their GP, then in case of an urgent medical problem the provider discussed this again with the patient to seek their consent. If patients agreed we were told that a correspondence was sent to their registered GP in line with GMC guidance. We saw an example of consultation notes having been shared with the GP with the appropriate patient consent.

If a patient needed further examination they were directed to an appropriate agency; being signposted to their own GP or to their nearest A&E department as well as referral letters to private consultants. The service monitored the appropriateness of referrals to ensure all referrals made were clinically appropriate.

Correspondence was shared with external professionals in a way that ensured data was protected. Information required passwords in order to access any data shared with external providers.

At the time of the inspection the service did not monitor or follow up pathology results or provide diagnostic tests directly. In cases where the service's GPs carried-out a consultation with a patient and felt that their symptoms required further investigation, they would refer them to an appropriate alternative provider.

The provider had a teenager confidentiality policy. After consultations encrypted clinical notes or referral letters were sent back to the patients' online app accounts with their consent.

Supporting patients to live healthier lives

The service identified patients who may be in need of extra support and provided links to websites which contained helpful information or signpost to the relevant agency or provider.

Are services caring?

Our findings

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

Compassion, dignity and respect

We were told that the GPs undertook telephone consultations in a private room and were not to be disturbed at any time during their working time. The provider carried out random performance reviews to ensure the GPs were complying with the expected service standards and communicating appropriately with patients. Feedback arising from these performance reviews was relayed to the GP. Any areas of concern were followed up and the GP was again reviewed to monitor improvement.

We did not speak to patients directly on the day of the inspection. However, we asked the provider to send an email to any patients who have had a consultation in the last three months asking for feedback about their experience of using the service, should they wish to provide this as part of the CQC inspection process. Two patients responded and provided positive feedback and said they felt the provider offered an excellent service.

The service was not registered with any online review websites at the time of our inspection but we reviewed the patient survey information collected by the provider. At the end of every consultation, patients were able to submit their feedback via their online account at the provider's app. In the 11 months prior to the inspection 172 out of 173 patients had provided the positive (thumbs up) feedback about the service. Ninety patients had submitted positive feedback by typing in the comment box. We reviewed some patients' feedback available on patient consultations which was positive. Patients can also see how many times GPs have been 'liked' by other ZoomDoc customers.

Involvement in decisions about care and treatment

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

Patients had access to information about the GPs working for the service and could book a consultation with a GP of their choice. For example, whether they wanted to see a male or female GP.

We reviewed six examples of medical records and they were personalised and patient specific which indicated patient were involved in decisions about care and treatment.

We found that interpretation services were not available for patients who did not have English as a first language. The registered manager informed us translation services were rarely required as patients usually attended with an English speaking relative or friend.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting patients' needs

Patients requested a telephone consultation (offered nationwide) or face to face consultation (offered in and around London) with a GP via the provider's app, where they could request an appointment with a specific GP and choose a convenient time slot. When the request was made the patient provided a short summary of their symptoms, which was then sent through to an on-call GP of their choice.

The service offered medical assessment, clinical examination, diagnoses, prescriptions and referral letters for private hospitals or private consultants. Sick notes could be supplied if required.

Patients signed up to receive this service on a mobile phone (iPhone or Android versions that met the required criteria for using the app). The service offered flexible appointments seven days a week all day every day and consultations could be booked via the provider's app to meet the needs of their patients. This service was not an emergency service. Patients who had a medical emergency were advised to ask for immediate medical help via 999 or if appropriate to contact their own GP or NHS 111.

The provider's app allowed people to contact the service from anywhere in the United Kingdom and all GPs were required to be based within the United Kingdom and registered with the General Medical Council (GMC).

The provider made it clear to patients what the limitations of the service were. For example, the private prescriptions were only issued by the visiting on-call doctor after face to face consultation, which could be processed electronically via eFax to a local pharmacy of the patient's choice or written on letterheaded paper.

The standard length of time for a telephone consultation was 10 minutes and a face to face consultation was 25 minutes. However, we were told that GPs were able to extend the consultations at additional cost if they had not been able to make an adequate assessment or give treatment.

Patients were able to contact the service within 24 hours after the consultation free of charge to discuss any concerns. Patients were able to speak to any on-call GP or request to speak to the same GP. If the same GP was not available then patients were able to set an alert through the provider's app to call back later on to ensure the continuity of quality care.

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 GPs available. Patients could choose either a male or female GP or one that spoke a specific language or had a specific qualification.

Managing complaints

Information about how to make a complaint was available on the provider's app. However, this information was not available on the service's website. 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 which included the complainant's right to escalate the complaint to the Independent Healthcare Sector Complaints Adjudication Service (ISCAS) if dissatisfied with the response.

We reviewed the complaint system and noted that comments and complaints made to the service were recorded. The service had received two complaints since they began operating 11 months ago and we reviewed both. The provider was able to demonstrate that the complaints we reviewed were handled correctly and patients received a satisfactory response. There was evidence that the service had provided an apology, fully or partially refunded the fee that the patient had paid, and used the information provided by the patient to review the service.

Consent to care and treatment

The service had a consent policy in place. All GPs we spoke with 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, staff carried out assessments of capacity to

Are services responsive to people's needs?

(for example, to feedback?)

consent in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP assessed the patient's capacity and, recorded the outcome of the assessment.

The service's pricing structure was clearly advertised on the provider's app. There were standard charges Monday to Friday from 8am to 6pm, which slightly increased during evenings, weekends and bank holidays.

There was clear information on the service's website and app with regards to how the service worked and what costs applied including a set of frequently asked questions for further supporting information. The website had a set of terms and conditions and details on how the patient could contact them with any enquiries.

The service gave patients clear information to help them make informed choices. Information about the cost of the consultation was known in advance and paid for before the consultation appointment commenced. The costs of any resulting prescription (dispensed from the doctors bag), extended consultation time, referral letter or medical certificate were added to the bill following the consultation and documented in the patient's notes. All payments were made using the credit or debit card saved within the patients' online account during the registration process.

Are services well-led?

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

Our findings

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

Business Strategy and Governance arrangements

The provider told us they had a clear vision to develop and expand their service in order to provide a high quality responsive service that put caring and patient safety at its heart. The provider had a mission which was to deliver the best possible person centred on-demand GP service. We reviewed business plans that covered the plans to expand the services provided.

There was a team of co-founders and advisors to provide support in developing the business strategy. There was a range of service specific policies which were available to all GPs. These were reviewed annually and updated when necessary.

There were a variety of regular checks in place to monitor the performance of the service. These included random performance reviews for consultations. The information from these checks was used to produce a clinical report that was discussed at quarterly clinical team meetings. This ensured a comprehensive understanding of the performance of the service was maintained.

Care and treatment records were complete, accurate, and securely kept.

There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, in some areas insufficient arrangements were in place to ensure that the service provided to patients was safe and effective; for example, in relation to the proper and safe management of medicines and staff training. The provider did not have a monitoring procedure in place to ensure the safety and effectiveness of the doctors bag.

Leadership, values and culture

The lead GP, who was also a founder and chief executive of the service had overall responsibility for any medical issues arising. The lead GP was the CQC registered manager and clinical lead for the service and attended the service daily. There were systems in place to address any absence of the lead GP and we were told that when the service expanded, further clinicians would be recruited to support the clinical management team. There were systems in place to manage the GPs' rota and to forecast demand and to ensure there were enough GPs available to meet any increase in demand.

The service focused on the needs of patients. The service's stated aims and objectives were to provide a safe GP triage and mobile doctors visiting service to give advice and treatment within patients' own homes, office or hotel.

The provider mission statement was stated on their website. 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.

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 encrypted IT systems in place to protect the storage and use of all patient information. The service could not provide a clear audit trail of who had access to records and from where and when; however, they had strict protocols in place with restricted access and only relevant authorised individuals were able to access records. The service was registered with the Information Commissioner's Office (ICO). There were an app system failure procedures and computer and data security procedures in place to minimise the risk of losing patient data. The service had arrangements in place to ensure that patient records could be retained for the required length of time should they cease to trade.

Seeking and acting on feedback from patients and staff

Patients could rate the service they received. This was constantly monitored and triggered a review of the consultations to address any shortfalls. At the end of every consultation, the patients were able to provide feedback by clicking "thumbs up" or "thumbs down" icons and were able to type feedback in the comment box via their online account on the provider's app. An anonymised rating of this feedback appeared on the electronic staff profile of the GP concerned which was viewable to all registered patients. However, the comments were only viewable to the management team.

Are services well-led?

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

The patients' views and concerns were encouraged, heard and acted on to shape services and culture. For example, the provider informed us they had made technical improvements in the app following feedback from the patients, which included adding a busy tab and alert feature in the app.

There was evidence that the GPs were able to provide feedback about the quality of the operating system and any change requests were logged, discussed and decisions made for the improvements to be implemented. Two GPs we spoke with confirmed this.

The service had initiated an online networking tool to communicate quickly with all GPs in the pioneer group. This networking platform was used to share information, peer support and monitor the resources.

The provider did not have a whistleblowing policy in place. (A whistle-blower is someone who can raise concerns about practice or staff within the organisation.) The registered manager informed us they would develop a new whistleblowing policy when they expand the service in future.

Continuous Improvement

There was a focus on continuous learning and improvement at all levels within the service.

Two GPs we spoke with informed us that they could raise concerns and discuss areas of improvement with the clinical lead as and when required. All GPs were encouraged to identify opportunities to improve the service delivered.

We saw from minutes of staff meetings where previous interactions and consultations were discussed.

The service consistently sought ways to improve. All co-founders and advisors were involved in discussions about how to run and develop the service.

There was a continuous improvement strategy and plan in place to expand the service. For example:

- The provider had recently raised finance to grow and expand further.
- The provider was currently interviewing and seeking to bring a number of non-executive directors on-board.
- The provider was planning to install a new identity checking system within four months, which would enable to verify patient's identity at the registration stage with the assistance of a third party company.
- The provider was planning to offer video consultations within six months.
- The provider was planning to improve technical features in the provider's app which would enable the patients to book appointments in advance with a GP of their choice to promote continuity of care.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The provider did not ensure proper and safe management of medicines. In particular: The protocol for prescribing did not include the clear guidance for visiting GPs regarding the safe prescribing of off-licence medicines, benzodiazepines, the oral contraceptive pill and hormone replacement therapy. The provider's medicines policy did not include the safe storage guidelines for Glucagon, which is affected by exposure to very hot or cold temperatures. The provider did not have a monitoring procedure in place to ensure the safety and effectiveness of the doctors bag. The provider had not carried out infection control audits. The provider was unable to provide evidence that all GPs had received training in health and safety and infection control. **Regulation 12(1)(2)**