Vantage Diagnostics Headquarters

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.

Previous inspection 29 November 2018, when we found the provider was meeting the relevant standards.

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 Vantage Diagnostics Headquarters on 6 August 2019 as part of our current inspection programme. We previously inspected this service on 29 November 2018 using our previous methodology, when we found the service was compliant with the relevant regulations. At that inspection, we did not apply ratings.

The Vantage Diagnostics Ltd (the provider) offers an online dermatology consultancy triaging service (known as "teledermatology") to general practitioners using digital photography and dermoscopy. The service allows GPs to submit photographs of rashes and lesions remotely for review by consultant dermatologists, who provide the GPs with a report including diagnosis, triage and treatment advice. Clinical responsibility for patients' healthcare remains with their GPs. The service is not provided directly to patients and does not involve prescribing any medicines. At present the service is provided only to the West Suffolk Clinical Commissioning Group (CCG).

The provider's Clinical Liaison and Transformation Director is the registered manager for the service. 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.

At this inspection we found:

- Risks were assessed and action taken to mitigate any risks identified. Arrangements were in place to safeguard people.
- Suitable numbers of staff were employed and appropriately recruited. Staff received the appropriate training to carry out their role.
- The provider carried out checks to ensure reviews met the expected service standards. A range of information, including clinical audit, was used to monitor and improve the quality and performance of the service.
- The provider did not have any direct patient contact, but it took account of the views of the commissioning CCG and participating GPs in delivering services. Patients' consent was required before reviews were accepted by the service's IT system. Patient information was held securely. Information was appropriately shared with a patient's own GP in line with GMC guidance.
- Information about how to complain was available and complaints were handled appropriately.
- The provider had clear leadership and governance structures.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was comprised of a CQC lead inspector and a GP specialist adviser.

Background to Vantage Diagnostics Headquarters

Vantage Diagnostics (the provider) offers an online dermatology consultancy triaging service to general practitioners using digital photography and dermatoscopy. A dermatoscope is a medical instrument with a light and magnifying lens, that can be attached to a digital camera or phone. The service allows GPs to set up referrals to submit photographs of patients' rashes and lesions remotely for review by consultant dermatologists, who provide the GPs with a report including diagnosis, triage and treatment advice. Clinical responsibility for patients' healthcare remains with their GPs, which includes making any routine referrals to secondary care. The reports are issued to GPs within three working days of the photographs being submitted. The service is provided under a contract with one NHS CCG – West Suffolk – with 24 participating general practices and approximately 200,000 patients. The service is not provided directly to patients and does not involve prescribing any medicines. There are no age-restrictions, with GPs being able to refer children under the age of 18-years to the service. But in practice most patients referred are adults.

The provider was registered by the Care Quality Commission under the Health and Social Care Act 2008 in January 2013, in relation to the regulated activity Transport services, triage and medical advice provided remotely. The provider has other elements to its business which are outside the scope of CQC registration. These include the provision of decision support and workflow management software to healthcare providers. It also provides the dermatology triage IT system and technical support to another CCG, but it is not responsible for clinical reviews in that instance.

The teledermatology service to West Suffolk CCG has been provided since October 2014. Approximately 1,000 referrals had been reviewed in the last 12 months. The contract was recently extended for a further year.

The provider operates at Barkat House, 116-118 Finchley Road, London NW3 5HT, where its management, technical, administrative and support staff are based. Clinical staff are based elsewhere and access the service's online system remotely using suitable security protocols.

How we inspected this service

This inspection was carried out by a CQC inspector and a GP specialist adviser.

Before the inspection we gathered and reviewed information from the provider and feedback from the CCG. During the inspection we spoke with the provider's Chief Executive, the Clinical Liaison and Transformation Director, who is also the registered manager, and members of the administration team. 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. We also spoke with the main clinician, a consultant dermatologist, who is a doctor registered with the General Medical Council (GMC) with a licence to practice.

We reviewed the provider's operating procedures and governance policies and looked at a number of triage review records.

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.

Good

Are services safe?

We rated safe as Good because:

Keeping people safe and safeguarded from abuse

The provider had up-to-date policies relating to safeguarding vulnerable adults (reviewed in July 2019) and children (April 2019). Staff, including clinicians, had adult and child safeguarding training to a level appropriate to the role and responsibilities. It was a requirement for clinicians registering with the service to provide evidence of current safeguarding training certification. Staff knew how to recognise signs of abuse. They had online access to the safeguarding policies and guidance and knew where to report a safeguarding concern, having contact details for the relevant safeguarding authority.

Monitoring health & safety and responding to risks

The provider's headquarters was located within modern offices and all staff based there had received training in health and safety including fire safety. No patients attended the premises. We saw the provider had an up-to-date health and safety policy (reviewed in April 2019) and that a fire risk assessment of the premises had been conducted in November 2018. We were shown evidence of regular fire drills and fire alarm testing, as well as water system management checks appropriate for office buildings. There was a current business continuity plan, reviewed in February 2019, which provided for the service to be relocated should the premises be unusable. Portable appliance (PAT) testing had been carried out on electrical equipment, including equipment issued to remote staff, in November 2018 and the building's fixed wiring had been inspected and certified in June 2017. We saw evidence that work station risk assessments and been carried out and staff away from the office were required to complete a home working risk assessment to ensure their working environment was safe. There was a three-year service contract in place, commencing in March 2019, relating to the 30 dermatoscopes used in the service.

The provider's IT system was run from a secure "Tier 4" data centre. Tier 4 data centres are maximum-rated locations in relation to security and operational aspects, compliant with the relevant standard ISO 27001. Annual penetration tests of the system were carried out. The provider achieved a 100% rating for the NHS Digital IT Governance toolkit in March 2019 and in previous years. Clinicians carried out their reviews of photographs remotely online. The photographs submitted by GPs did not contain any patient-identifiable data. Clinicians and any home-based workers accessed the system using a secure two-factor authentication.

Staff provided participating GPs with full training and detailed written and video guidance in using the equipment and IT system to set up referrals and submit photographs. Ongoing support to the participating GPs was provided both online and via a telephone helpline, which operated between 8.00 am and 6.00 pm, Monday - Friday.

We were shown the provider's range of up-to-date policies relating to risk management and incident reporting and investigation, which were available to all staff on the IT system. These set out the reporting process and identified staff responsible for assessing and managing risks, including timescales for investigations and reviews. They also highlighted the need to report certain matters to outside agencies such as the National Reporting and Learning System (NRLS) and to submit statutory notifications to the CQC.

The provider had systems in place for regular auditing of triaging referrals. This involved a review of approximately 10% of referrals every six months and this process was linked with auditing undertaken by the commissioning CCG. The provider had regular meetings with the service commissioners to discuss issues and concerns. In addition, there was a range of internal staff meetings, where standing agenda items covered topics such as significant events, complaints and service issues.

Staffing and Recruitment

There were enough staff, including clinicians, to meet the demands for the service. The main clinician, an independent consultant dermatologist, was employed by the provider as a sub-contractor. The provider had arrangements in place with other dermatologists who were familiar with the service system being available to cover the main clinician's absence. Any additional cover could be provided by an agency, but this had not been necessary to date.

The provider had a range of human resource governance policies in place, including recruitment and selection processes. There were a number of checks that were required prior to staff commencing employment, such as obtaining two references and Disclosure and Barring

Good

Are services safe?

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.

The provider had a process for the induction and training of new staff and in respect of ongoing training. Potential clinicians had to be registered with the GMC. They had to provide evidence of having professional indemnity cover, an up-to-date appraisal and certificates relating to their qualification and training in safeguarding. The provider retained evidence of these, which it showed us. New staff were subject to a standard three-month probation period; longer periods applied to particular roles, such as trainers. We were shown various policies relating to staff training, appraisal, supervision and development, capability and performance, anti-bribery and corruption and malpractice. We saw records confirming the clinician's most recent appraisal had been conducted in July 2018, with this year's appraisal scheduled, and other staff members' annual appraisals were up-to-date. The provider sent us a copy of the main clinician's 2019 appraisal for shortly after our inspection.

The provider kept records for all staff, including clinicians. We saw necessary documentation, including records of professional registration and insurance cover, was maintained. There was a system in place that flagged when registration or insurance cover was due for renewal and when refresher training required by the provider should be given. We reviewed five staff personnel files and confirmed they contained the appropriate records.

Information to deliver safe care and treatment

The triaging service was carried out using anonymised data and photographs submitted by participating GPs. However, the service's IT system interfaced with those of participating GPs to ensure patients' identity was verified.

Management and learning from safety incidents and alerts

The provider had up-to-date policies relating to Clinical Risk Management, as well as incident reporting and investigation. All staff had access on the IT system to standard incident reporting forms. We were shown the provider's clinical safety hazard log, a risk assessment of 18 potential issues that might adversely impact on service provision, which had been reviewed with control measures discussed, agreed and implemented. The log was reviewed and updated on an on-going basis and shared with stakeholders appropriately. There had been no significant incidents regarding the dermatology triaging service. However, the provider applied learning from other related aspects of its business. Incidents were reported and investigated. They were monitored by management and reviewed in an annual report to identify any trends and bring about improvement where necessary. Learning from incidents was shared at team meetings and via internal newsletters.

We saw the provider had an up-to-date policy "Being Open", reviewed in April 2019, which specifically related to the duty of candour. This gave staff guidance on how to respond to people who had been affected by an incident or to those who submit complaints: by providing a chronology of events and facts; explaining to the person what went wrong; offering an apology; and advising them of any action taken.

Good

Are services effective?

We rated effective as Good because:

Assessment and treatment

We were told clinicians assessed patients' needs and delivered care in line with relevant and current evidence-based guidance and standards. This included guidance issued by the National Institute for Health and Care Excellence (NICE), the British Teledermatology Society and the British Association of Dermatologists together with the Quality Standards for Teledermatology, published by Primary Care Commissioning. Guidance was received and reviewed by the Clinical Liaison and Transformation Director or an identified deputy. In addition, guidance issued by the service commissioner was incorporated into operational procedures and local care pathways were set out in the CCG's service leaflet, which was given to patients by participating GPs.

GPs submitting triage referrals used standard templates, which included an anonymised medical history and confirmation of the patient's consent being given. The GPs took photographs of the patient's lesion and uploaded them onto the clinical system using the secure NHS link. The clinician reviewed the submission and provided a report within three working days of receiving the photographs. The provider's system triggered an alert on the third day, prompting help desk staff to contact the clinician with a reminder.

The report provided a diagnosis and a recommendation for treatment, either within the GP practice or secondary care. Clinical responsibility for patients' healthcare remained with their GPs, which included arranging any necessary referrals to secondary care. Use of the service by participating GPs was limited to appropriate cases, as defined by national and local guidelines, for example GPs were instructed not to refer cases of suspected cancer (two-week referrals) to the triaging service. An escalation procedure was in place relating to significant healthcare concerns and the need for urgent treatment being identified. Since our last inspection, a new provision had been introduced under local arrangements in West Suffolk, whereby suspected urgent cases identified during triaging could be referred directly by the provider to secondary care services for investigation and diagnosis. The patients' GPs were informed automatically by the system when this process was triggered. In all an alert was raised on the clinical system when referring GPs had not checked the triage results within a set period. This prompted the provider's administrative and support team to email the GP or contact them by telephone. The provider monitored the response times and showed us data relating to the most recent 700 referrals, of which approximately 41% had been completed the same day; 34% within one day; 15% within two days and 5% within three, leaving approximately 3% taking longer than three days. The 700 referrals had also been audited identifying that 70% of them received follow up care or treatment from their GPs, with 30% being referred on to secondary care providers.

With the provider's main clinician, we reviewed five patient referrals records, relating to various conditions and diagnoses. We established the referrals had been reviewed and processed appropriately.

The provider and the service commissioner were aware that working remotely had both strengths (speed, convenience) and limitations (inability to perform physical examinations or discuss issues with patients). We noted this was made clear in the CCG's service leaflet given to patients by the GPs, in accordance with the Quality Standards for Teledermatology. We discussed with the provider, which agreed to include similar guidance information on the consent form patients signed when seeing their GPs. The provider sent us the revised consent form soon after our inspection.

Quality improvement

The provider collected and monitored information on triage service.

- The provider collected and gave the service commissioner performance data at regular intervals in accordance with the service contract. There were quarterly review meetings with the commissioner and regular meetings with the clinical group of participating GPs to discuss and review service issues, including audits, to identify where changes and improvements might be made.
- The IT system had an inbuilt auditing facility allowing the provider and participating GPs to review and assess the quality of referrals and reporting on an ad hoc basis.
- The provider carried out formal quality improvement activity, for example audits of 10% of triage reviews over a six-month period. The audits were conducted by the independent consultant dermatologists working for the provider, reviewing each other's cases. We saw the result of a recent audit of 54 randomly selected cases, from

the period January to July 2019. The audit results were satisfactory, concluding that 53 of the 54 reviews had provided a reasonable diagnosis; 51 of the 54 had provided a reasonable management plan; and 54 of the 54 had provided a reasonable triage outcome. The auditors provided feedback and comments, which were reviewed by the provider and CCG at regular engagement meetings. The Feedback was also passed on to the consultant who had undertaken the original reviews, for learning and development purposes. The Quality Standards for Teledermatology state that where excision or biopsy is recommended there should be audit of the clinical diagnosis. This auditing was done by the commissioning CCG and since our last inspection a process had been established to link the CCG's audits with the provider's so that common cases were reviewed.

Staff training

We reviewed all the staff members training records. All staff had completed induction and ongoing training such as general health and safety and fire safety; safeguarding; basic life support; information governance; infection prevention and control; equality and diversity. There were two trained first-aiders and two trained fire marshals. Full training was also provided on the use of the clinical system and staff had recently undertaken training in respect of the General Data Protection Regulation (GDPR). The provider maintained a training matrix which identified when training was due. When the provider's policies and procedures were reviewed and amended, staff were required to acquaint themselves with the documents and sign a log confirming they had done so.

Managers and administration staff received regular performance reviews. The main clinician had received an appraisal in July 2018. We saw it included their teledermatogy work for the provider, including the audit results, which was also relevant to their revalidation. The next appraisal was scheduled to take place two weeks after our inspection. The provider sent us evidence of it taking place shortly after our visit.

Coordinating patient care and information sharing

All the triaging carried out under the service was done following referrals by the participating GPs. The system connected with the GPs' patient records using the secure NHS link. GPs entered relevant information on a standard template and submitted it with one or more digital photographs of the lesions. The consultant provided a report, including diagnosis and a treatment plan. The service had provision for urgent secondary referrals to be made directly by the provider, with patients' GPs being informed appropriately.

Good

Are services caring?

We rated caring as Good because:

Compassion, dignity and respect

The service did not provide direct patient care or treatment. However, staff had received training in aspects such as customer care and equality and diversity.

Involvement in decisions about care and treatment

The service did not provide direct patient care or treatment.

Participating GPs provided patients with a service leaflet, produced by the commissioning CCG, which explained the triaging process, including the limitations of the service compared with a face-to-face examination. Discussing and agreeing on care and treatment with patients' decisions was the responsibility of participating GPs, in accordance with local care pathways. However, there was provision for urgent secondary referrals to be made directly by the provider to a West Suffolk hospital.

Those patients who requested it could be provided with secure access for the system, to see their results. The reviewing consultant was named in the report. The provider told us that approximately 10% of patients had opted for access to their triage reports. It ensured that appropriate and accessible terminology was used in the reports, suitable for the patients to see, should they wish.

The triage system had a facility to obtain feedback from patients, which was shared with the CCG and participating GPs. We saw the most recent data, relating to referrals over the previous eight months, which showed positive results: 62 patients had responded, of whom 34 (55%) said they were very satisfied with the service; a further 23 (36%) said they were satisfied; the remainder being neutral. The data also showed that 58 patients (94%) said they would recommend the service.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

Responding to and meeting patients' needs

The provider did not have any direct patient contact, but it took account of the views of the commissioning CCG and participating GPs in delivering services.

There were quarterly meetings with the commissioning CCG and regular meetings between the provider and the clinical group of participating GPs. In addition, there was ad hoc contact via email and the provider's Helpdesk. We were shown a log of actions taken by the provider in response to Helpdesk contacts from participating practices, including clinic codes being added the system and training being given in relation to rejecting certain referrals. Before the inspection we contacted the West Suffolk CCG, which gave us positive feedback about the service and the provider's performance.

The provider monitored the turn-round times of the triaging, with 97% of referrals being completed within three days of the photographs being submitted on the system. It had introduced a process since our last inspection for urgent referrals to be made directly with secondary care providers.

Patients were informed of the limitations of the service in the leaflet they were given by their GPs. They were able to request secure log-on details to access the system and their results online.

Tackling inequity and promoting equality

The provider carried out the triaging service on all referrals made by the participating GPs without discrimination. The provider had an up-to-date equality and diversity policy and all staff had received relevant training.

Patients who opted for access to their triage records could identify the clinician responsible. The reports were worded in accessible, understandable terms.

Managing complaints

There had been no complaints regarding the service. However, we saw the provider had an up-to-date complaints policy, reviewed in April 2019. The policy contained appropriate timescales for dealing with complaints and there was 3-stage escalation procedure allowing for resolution at local level, an internal appeal procedure and thereafter a review by an independent external adjudicator. A template form for recording complaints was in use and was available to all staff, together with the complaints procedure guidance, on the provider's IT system. Complaints were a standing item on staff meeting agendas, allowing for any learning to be shared, and there was a formal management review programmed quarterly for monitoring. The provider had policies to ensure complaints were dealt with in accordance with the duty of candour.

Consent to care and treatment

Patients were required to give their consent to treatment. The provider showed us a form produced by the commissioning CCG, which contained sections for both the patient and the GP to complete and sign. It included specific consent to photographs being taken by digital camera or a smartphone and the patient could give or withhold consent to their photographs being used for educational purposes. We noted the form did not contain a space for the photographer, if other than the GP, to complete, in accordance with the Quality Standards for Teledermatology. We discussed this with the provider and were sent a copy of a revised form, which would be used in future, after the inspection. The review template submitted by participating GPs would be rejected by the IT system unless patients' consent was specifically recorded.

Good

Are services well-led?

We rated well-led as Good because:

Business Strategy and Governance arrangements

The provider had a clear vision to deliver a high-quality responsive service. There was a strong organisational structure and staff were aware of their own roles and responsibilities. There was a range of service-specific policies which were available to all staff. These were reviewed annually and updated when necessary. When changes were made, staff were required to acquaint themselves with the revised policies and sign a log confirming this.

There were a variety of regular checks in place to monitor the performance of the service. This information was monitored by managers to ensure a comprehensive understanding of the performance of the service was maintained. Other monitoring was done in accordance with the service contract and reported back to commissioners. The system flagged when any tasks were due, such as reviews nearing the three-day deadline, or participating GPs not reading reports, triggering action by staff.

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

Leadership, values and culture

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services.
- Leaders were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The provider had effective processes to develop leadership capacity and skills.
- There was an up-to-date staff handbook and various detailed policies relating to employment issues.

The provider had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values.
- The provider had a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.

The provider had an open and transparent culture. We were told if there were unexpected or unintended safety incidents, the provider would give affected patients reasonable support, truthful information and a verbal and written apology. This was supported by an operational policy, "Being Open".

Safety and Security of Patient Information

Triage review records were complete, accurate, and securely kept. The provider had a range of up-to-date governance policies, such as Records Management, Network Security and Information Governance. It had achieved a 100% rating for the NHS Digital IT Governance toolkit in March 2019 and in previous years. There was a clear audit trail of who had access to records and from where and when. The provider was registered with the Information Commissioner's Office as an information processor. There were business contingency plans in place to minimise the risk of losing patient data.

Seeking and acting on feedback from patients and staff

Participating GPs were able to provide ad hoc feedback about technical aspects of the service and its overall performance and quality. We saw examples of changes made following feedback. There were regular review meetings with the clinical group and the service commissioner.

Staff were able to provide feedback and recommend improvements. Staff told us there were formal team meetings every six months, where they could raise concerns and discuss service issues. However, as the management and administrative and support teams worked together at the headquarters there was ongoing discussion at all times about service provision.

There was a quality improvement strategy and systems in place to monitor quality and to make improvements, for example, through audits of reviews.

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 Chief Executive Officer was the named person for dealing with any issues raised under whistleblowing.

Continuous Improvement

Good

Are services well-led?

The provider 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. Staff were encouraged to reflect on practice and identify and share learning points. There was regular contact with stakeholders allowing feedback on the service, to identify where improvement could be made.

The provider had a policy on sustainable development, covering such issues as waste management, transport and travel, energy saving and carbon reduction.