Forward Clinical Limited

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	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Overall summary

Letter from the Chief Inspector of General Practice

We rated this service as Requires improvement overall.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced first comprehensive inspection of the service over two days, 27 July and 4 August 2021, as part of our inspection programme.

Forward Clinical Ltd (the provider) was registered by CQC on 20 May 2021. It operates an online consultation service using an application called *Juno*, whereby people can engage in a secure instant text message exchange using their iPhones and Android Smartphones with a clinician to discuss and receive advice on maternity and children's healthcare issues. People using the service pay a monthly subscription. The service does not include providing treatment, prescribing drugs or medications, or referral to secondary healthcare providers.

At this inspection we found:

- The provider had processes to monitor the performance of the service, but these were limited due to senior clinical staff having restricted access to records, preventing full and effective assessment, monitoring and clinical auditing.
- We could not establish that all service users' records were complete as in some cases information was recorded outside the main Juno service system.
- Governance policy documents had not been sufficiently reviewed and amended to be appropriate and specific to the service. Some contained discrepancies and errors.
- The provider had systems to manage risk, so that safety incidents were less likely to happen. When they did happen, the provider learned from them and improved their processes.
- The provider routinely reviewed the effectiveness and appropriateness of the advice it gave service users. It ensured that this was delivered in accordance with evidence-based guidelines.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- Service users could access the service within an appropriate timescale for their needs. User feedback that we saw, and which was provided directly to us, was consistently positive regarding caring and responsive aspects of the service.

The area where the provider **must** make improvements is:

- It must establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Please see the specific details on action required at the end of this report.

Overall summary

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

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

Background to Forward Clinical Limited

Background

The provider was registered by CQC on 20 May 2021 in respect of the regulated activities *Treatment of disease, disorder or injury* and *Maternity and midwifery services.*

At the time of registration, the provider operated from offices at 300 St. John Street, London EC1V 4PA. However, it has now moved to a fully remote working model for all staff – clinicians, management and administrative officers and technicians. The location remains the provider's registered office address and the provider retains access to meeting room facilities there.

The provider operates an online consultation and advice service (the service) using a proprietary application (app) called Juno. Using the app, people can engage in a secure text exchange with a clinician to discuss and receive maternity and paediatric advice and support throughout a pregnancy and up to six weeks postnatally, together with obtaining advice on health issues relating to children aged under-16 years. The service was originally limited to Apple iPhones, but the Juno app for Android devices was recently made available. The service operates between 8:00 am and 8:00 pm seven days a week. It is available to people who reside and are located in England at the time of the consultation. It does not include prescribing drugs or medications or routine referral to non-urgent secondary care provision. Nor is it designed to provide emergency care or ongoing advice for long term health conditions. People contacting the service in those circumstances are referred to emergency providers such as 999 or the local Accident and Emergency (A&E) department, or NHS 111. When necessary, clinicians may contact the paediatric team at the relevant A&E department to advice of a child's referral and attendance.

People register to use the service and pay a monthly subscription. To register, they must be over-18 years of age. They can then set up secure instant text message exchanges with duty doctors and midwives to discuss issues relating to maternity and their children's health. When necessary to assist diagnosis, service users can attach photographs or other files for clinicians to access and advise on. Although the service does not include arranging tests, results from tests arranged elsewhere can be discussed with clinicians.

The clinicians are all registered with the relevant professional bodies. They are employed by the provider as independent practitioners and when not engaged with the service they work for the NHS in England. At the time of the inspection, there were 17 paediatric-specialist doctors, including consultants, and 17 midwives contracted to the provider, operating various duty shifts. It is a condition of their contracts that they do not work Juno service shifts whilst on duty with the NHS. The provider has around 30 managerial, administrative and technical staff.

Information regarding the service can be found on the provider's website – www.hellojuno.co.uk

How we inspected this service

Before the inspection we gathered and reviewed information from the provider. We conducted the inspection by a series of online interviews with the provider's co-Chief Executive Officer, the clinical lead, the interim lead midwife, the current and prospective registered managers and other staff. We reviewed a range of the provider's policies and procedures and patient consultation records. We did not speak with service users but received some direct feedback and reviewed other sources where their feedback was recorded.

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.

Requires Improvement

Are services safe?

We rated safe as Requires improvement because:

Current system data security measures restricted senior clinicians' access to service users' records limiting full clinical oversight. Information relating to clinical discussions was recorded outside the service app, meaning the service users' records were not always complete. Some governance documentation required review, amendment and implementation.

Keeping people safe and safeguarded from abuse

The provider ensured that staff employed within the service were trained in safeguarding to levels appropriate to their roles and responsibilities – level 3 for doctors and level 2/3 for midwives. It was a requirement that all clinicians registering and contracting with the provider to work in the service submitted evidence of up-to-date safeguarding training certification. The clinical lead was also responsible for leading on safeguarding issues and was trained to level 5. Training for the provider's administrative and technical staff (to level 1) was by a recognised online training provider specialising in healthcare.

The provider had safeguarding policies which all staff could access, together with various other guidance documents such as a service manual. There was a process for identifying the safeguarding teams for the service users' local area. We discussed some issues regarding the safeguarding policies and the provider agreed to review them and include references to identify the safeguarding lead and a deputy. The provider told us after the inspection that this had been corrected. We noted that some references were made in various other governance documents to provide staff with guidance on safeguarding issues. The provider told us that all governance documents would be reviewed, consolidated and simplified for easier reference.

The provider had escalated for review six service user engagements with potential safeguarding issues. We reviewed these and concluded they had been addressed and actioned appropriately. We saw evidence that learning from the incidents, as well as safeguarding generally, was discussed and shared across the team during knowledge sharing sessions at monthly meetings. This included signposting clinicians to safeguarding guidance material issued by the Royal College of Paediatricians and Child Health (RCPCH).

Monitoring health & safety and responding to risks

When registering, service users were required to submit evidence of photographic ID and certain personal data which was stored securely and used for future security monitoring and identification. This included their name and that of the child (if registering for paediatric advice), details of their GP; if the child was known to social services (if applicable); whether they resided and were currently in England. Payment of the subscription fee was made by credit or debit card. At the commencement of each consultation engagement, service users had to resubmit the ID evidence and information and if any discrepancy with the stored information was identified the consultation would not proceed. The provider told us an established user ID verification system had been identified and would be implemented shortly, once legal and commercial due diligence checks were completed.

There were secure system arrangements for clinicians to access the Juno service app at the beginning of their duty shifts. The provider required the clinicians to conduct consultations in private to maintain service users' confidentiality. In practice, this meant the clinicians worked mostly from home. The staff duty roster typically scheduled two paediatric clinicians per shift; usually one more junior (of registrar grade, for example) to engage with service users as first responder, with a duty consultant always available to provide advice if needed. We were told the clinicians communicated with each other using another of the provider's established proprietary messaging apps, outside the Juno service app.

Requires Improvement

Are services safe?

At the end of a consultation chat exchange, a *Discharge Summary* was created, shared with the service user and saved within the Juno app. It could be accessed by the service user and authorised staff and, where consent was provided by the service user, shared with their GP. The chat exchanges could also be *flagged* if there were any safeguarding concerns; if the exchange had prompted a shared learning opportunity or any issues for potential future development of the system; or if it highlighted any element of good practice. The provider told us just under 3% of exchanges had been flagged for review. Some had led to system development and procedural changes, such as the ID evidence requirement at the beginning of each consultation exchange.

The provider's technical staff carried out real-time monitoring of the system and appropriate service logs were maintained. These were discussed at regular meetings. We saw the provider had a risk management process and maintained a risk register. This recorded identified risks and means of mitigation, together with ongoing action plans and monitoring arrangements.

Information to deliver safe care and treatment

Service user's healthcare information was stored within the Juno app, rather than on their phones. We were told that as a data security measure only clinicians currently assigned to an ongoing exchange consultation could access the relevant archived record for that particular service user. The only exception to this was when a particular exchange had been flagged in the system by the clinician conducting the exchange, whether for safeguarding reasons or if it had highlighted learning issues or aspects for potential system development. This limited senior clinicians' ability to undertake full monitoring and audit. Technical staff told us wider ranging records searches could be run, but they were not able to demonstrate the process for us during the inspection call. We asked the clinical lead to demonstrate their access to records and saw this was hampered by them using only by their phone, rather than by a full-size computer screen. We discussed this with staff and were told the process would be reviewed.

In addition, during the initial stage of the inspection, we discussed circumstances when clinicians might need to escalate a concern and seek advice from the on-duty service consultant. Staff told us this was not often required. When necessary the interaction was conducted via another secure app, also developed by the provider, but outside the Juno system. Although a record of the exchange was made in the other app, it was not included in the Juno service record. This meant in those circumstances the service users' records might not be considered complete. We saw that this had been noted previously by the provider during service monitoring and staff told us the matter would be addressed in future system upgrades. As an interim measure the Juno service Discharge Summary would be revised to flag that an exchange had taken place between clinicians in the other messaging system. We returned to this in a subsequent interview, when we were shown a demonstration of how an exchange between a clinician and consultant could be recorded, exported as a *patient card* from the other app, and stored in the service user's Juno consultation record. We were told that this would be done in all relevant cases moving forward.

Users were informed at the time of sign up that the service was not intended to be a substitute for their primary care providers (their GPs) or as an emergency contact. However, the provider did have escalation processes in place to manage any emerging or urgent medical issues during a consultation exchange. In paediatric cases, if clinicians identified a need for service users to attend a hospital emergency department, they would ask the name of their local hospital and contact the on-call paediatric registrar to inform them of the attendance.

The provider held a range of regular meetings, involving clinical staff, managers, technicians and administrators. Various topics were covered such as flagged service user exchanges (eg. those with potential safeguarding concerns, or any

learning / developments issues), significant events, user feedback and complaints, service and system development issues. Clinical discussions included knowledge sharing sessions involving case reviews and clinical updates. These were conducted online, with video recording, several of which we viewed, and written summaries of the sessions were passed to all clinicians. They were also encouraged to view the recordings.

Staffing and Recruitment

The provider employed enough staff to meet the demands for the service. The provider had a selection and recruitment process in place for all staff, but this was not set out in a formal protocol or policy. All staff were subject to pre-employment checks, including providing photographic proof of ID, obtaining two work references and being subject to a Disclosure and Barring Service (DBS) check. 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 clinicians had to be currently working in the NHS and be registered by the relevant professional bodies – in the case of doctors by the General Medical Council, with a license to practice; midwives by the Nursing and Midwifery Council. The provider stipulates the same training requirements as the NHS, and clinicians applying to work in the service must provide satisfactory evidence of completed training and qualifications, together with records of their last three annual appraisals. Doctors must provide evidence of current professional indemnity insurance. The provider arranged additional insurance cover in respect of the doctors' work within the service.

Newly recruited clinicians underwent a standard induction process, involving familiarisation with the provider's service guidance, discussions with the clinical or midwifery leads and participating as a supernumerary on two trial duty shifts, involving a feedback discussion. Satisfactory completion of the two shifts was necessary before clinicians' appointment was confirmed.

We saw the provider kept recruitment and employment records for all staff and there was a system in place that flagged such matters as professional registrations or mandatory training refreshers becoming due. Required training was undertaken with an established online provider which specialised in healthcare-related training.

We saw that advance rotas were drawn up to ensure there was appropriate clinical cover for all shifts, including a first responder and consultant being available. Busy times, such as weekends, had been identified and more staff were on duty during such periods. Sufficient technical and support staff were also on duty while the service operated to deal with any system problems.

Management and learning from safety incidents and alerts

There was a procedure set out in the provider's incident management policy for identifying, investigating and learning from incidents relating to the safety of service users and staff members. For example, consultation exchanges could be flagged by the clinician if they related to safeguarding matters or raised clinical issues worthy of review, including examples of good practice. We saw from the notes of a knowledge sharing session that in addition to this, clinicians were asked to notify the clinical lead of any flagged exchanges so that learning points could be discussed and circulated *as in NHS practice*. We saw two examples of flagged cases being reviewed by this means.

Requires Improvement

Are services safe?

There had been no significant incidents that had adversely impacted upon service users. But we saw from the provider's governance policies that it was aware of the duty of candour to ensure openness and honesty when communicating with service users and their families following an incident where there is a risk or possibility that an incident could lead to or result in harm.

The provider's risk assurance policy also set out the process for monitoring and actioning safety alerts, for example those issued by the Medicines and Healthcare products Regulatory Agency (MHRA). The registered manager and clinical lead received these from the NHS Central Alerting System. They were assessed for relevance and disseminated if applicable to the service. Alerts would be discussed at knowledge sharing sessions, but none related to the service had been issued in the two months since the provider's registration. The provider told us several of the core clinical team were safety leads for their NHS Trusts and were consequently notified directly of all MHRA and Royal College of Emergency Medicine alerts. They said any relevant alerts are shared using the messaging app, outside Juno.

Requires Improvement

Are services effective?

We rated effective as Requires improvement because:

Current system data security measures restricted senior clinicians' access to service users' records limiting full clinical oversight. Information relating to clinical discussions was recorded outside the service app, meaning the service users' records were not always complete. Some governance documentation required review, amendment and implementation.

Assessment and treatment

People intending to subscribe to the service completed an online questionnaire. It was a condition of registration that they submit information including a past medical history, which was *true, accurate, current, and complete in all respects.* They were advised that the service was not a substitute for their primary care provider, and they should contact their GP immediately if health conditions change, or symptoms worsen. They were further advised not to use the service in a medical emergency, but instead call 999 or visit their local Accident and Emergency (A&E) department. Service users were directed to contact NHS 111 between 8:00 pm and 8:00 am, when the service did not operate.

Clinicians working in the service were aware of both the strengths (speed, convenience, choice of time) and the limitations (inability to perform physical examination) of working remotely from service users. They worked to maximise the benefits and minimise the risks for patients. If a physical examination was necessary, service users were directed to their GPs or local A&E. The service did not include prescribing, but clinicians were able to advise service users of any appropriate over-the-counter medications. Nor were any tests arranged, although clinicians could comment on any test results a service user had obtained elsewhere, provided they were fully aware of the full medical history and all relevant background information.

The consultation exchange was by means of secure texts recorded within the Juno app in a chat format. The exchange was not saved to the service user's or clinician's phones. Service users could upload photos or other files for the clinician to access. Active consultation exchanges were not time-limited, but clinicians closed the exchange after one hour of a service users' inactivity. Staff told us previous chat exchanges could be reviewed when the service user initiated a further exchange. We asked if there was a process for service users to be contacted if the clinician had ongoing concerns. Staff told us this could be mentioned in the end of process discharge summary and that there had been occasions in exceptional circumstances, when service users had been contacted by phone.

We were told that service users' needs were assessed and delivered care in line with relevant and current evidence-based guidance and standards, including those published by the National Institute for Health and Care Excellence (NICE). We saw evidence that clinical assessment tools, such as the NICE traffic light system relating to children with fevers and a sepsis assessment tool were used during consultation exchanges. The provider's clinical governance policy stated it would monitor ongoing and new developments in healthcare, providing regular updates to staff including newly published NICE guidance affecting practice/advice. In addition, as with safety alerts, the provider said the clinicians were all employed by the NHS and would as a consequence have access to and be made aware of all current clinical guidance. These were shared within the clinical team via the secure messaging app.

With the clinical lead, we reviewed the records of 12 service user consultation exchanges and found the discussion and advice provided was appropriate. However, the records were limited to those to which the clinical lead had been assigned as the clinician managing those particular consultation exchanges. In addition, we had previously established from our discussions with staff that any interaction between the first responder clinician and a consultant was conducted and saved outside the Juno service app. Accordingly, we could not be certain that the records of the 12 examples we looked at were complete. We subsequently discussed this with the provider's senior management and were told that increased access rights had later been granted to the lead clinician to allow them to monitor and review all consultations.

Requires Improvement

Are services effective?

Quality improvement

We saw some evidence of quality improvement activity from minutes of meetings, and recordings and notes of knowledge sharing sessions, which included case discussions, reviews of new clinical guidance, etc. and patient feedback.

However, although the provider's senior clinicians monitored some consultations that had been flagged, as having potential safeguarding issues or worthy of review for learning purposes, the effectiveness of the process was limited. The security and access restrictions to service user records meant the process did not allow for fully representative random sampling and review of all consultation exchanges, such as those that had not been flagged for any reason. This restricted full and effective clinical oversight, but was likely to improve, following the granting of additional access rights to the clinical lead and other senior clinicians if appropriate. The provider's clinical governance policy mentioned a separate document, the clinical audit policy, but we could not establish whether the latter existed. The provider was able to confirm after the inspection that there was a policy.

We were shown the results of two audits carried out by the provider; a two-cycle general audit of consultation exchanges, which indicated an overall improvement, albeit with some mixed results; and an audit of consultation exchanges involving symptoms of fever. The fever audit was seemingly limited in scope due to the records-access issue. It included only those cases that had been assigned to the auditor as the clinician managing those particular consultation chat exchanges, and any previous chats with those particular service users, together with any flagged cases, which could be accessed for review purposes. Again, the granting of increased access rights to senior clinicians would improve the effectiveness of future audit processes.

Staff training

We were told the provider had not yet devised a formal training protocol. However, training was mentioned in the clinical governance policy and the risk assurance policy. The provider stipulated its training requirements were the same as those of the NHS. We saw that clinicians working within the service were required to produce evidence of their qualifications, training and experience. All staff were required to undergo an induction process, to familiarise themselves with the provider's policies and working practices. Staff completed various mandatory modules, including safeguarding, information governance, health and safety, etc., in an online system operated by an established training provider specialising in healthcare. The provider had a training record matrix which identified when refresher training was due.

We saw that a comprehensive guidance handbook was available to both doctors and midwives working in the service. These were regularly reviewed and updated and covered such matters as the IT system and technical support, conducting consultations, duties and responsibilities and links to NICE and RCPCH guidelines. Revisions and updates were discussed at meetings and in knowledge sharing sessions, followed up by written confirmation.

Administrative and technical staff appraisals were planned but had not yet been carried out due to the newness of the service. Clinicians were required to provide evidence of their last three NHS appraisals before being appointed to work in the service.

Coordinating patient care and information sharing

Before providing advice, clinicians ensured they had adequate knowledge of the subject's health, any relevant test results and their medicines history. There were examples of service users being signposted to suitable sources of treatment where this information was not available to ensure safe and suitable advice could be given.

Requires Improvement

Are services effective?

All service users when subscribing to the service were asked to consent to the provider sharing details of their consultations with their registered GP, and they were encouraged to do so themselves. Where service users agreed to share information, we saw this could be done by the provider sending a copy of the discharge summary to their GPs. These did not currently include the patient record card, noting any discussions between the first responder and consultant, although we were told this would be the case moving forward, following development of the system.

Good

Are services caring?

We rated caring as Good because:

Patient feedback that we reviewed and which we received directly was consistently positive regarding caring aspects of the service.

Compassion, dignity and respect

The provider's guidance documentation instructed clinicians to conduct the consultation exchanges in a private room and stated they were not to be disturbed at any time during their duty shift. We saw a regular audit was conducted every two months to monitor the consultations and confirm clinicians complied with the requirements, with the results being shared at meetings and knowledge sharing sessions. Service users were asked to provide feedback after each consultation. General feedback was discussed, with any specific issues raised with individual clinicians. We saw the service user feedback included on the provider's website was positive, as were the reviews on the Apple App Store for iPhone (192 reviews, with an overall rating of 4.9 out of 5). No reviews or comments have yet been posted for the Android version of the app, which was recently made available.

We did not speak to patients directly, but as part of the inspection process we asked the provider to inform service users so they could provide feedback directly to CQC. We were contacted by a total of seven service users whose feedback was consistently positive about caring aspects of the service, including their interaction with both clinical and support staff.

Involvement in decisions

Patient information guidance about how to use the service and technical issues was provided. There was a dedicated team to respond to any enquiries They were contactable initially by email or webform but could discuss concerns with service users by telephone. Information regarding doctors and midwives working for the service was available on the provider's website. Subscription fee information and terms and conditions were also set out on the provider's website.

A record of consultation exchanges was stored within the service app for future access. Following a consultation exchange, a discharge summary was produced which service users could pass to their GPs or secondary care providers, if appropriate.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

The service had been established in response to current problems over accessing healthcare. Service user feedback was routinely sought, monitored and used to drive improvement.

Responding to and meeting patients' needs

The service was established allow people quick access to registered paediatricians and midwives to receive advice and support. It was intended avoid unnecessary face-to-face appointments and to reduce the burden on GPs and hospitals. Service users paid a monthly registration fee for a rolling subscription. The terms and conditions including cancellation rights were set out on the provider's website.

People subscribing to the service could request a consultation at any time between 8:00 am and 8:00 pm, seven days a week. Outside that period, service users were directed to contact NHS 111. Provision was made for additional staffing cover at weekends, when the service was in greater demand. There was no limit on the number of exchanges people could request.

People were informed it was not intended as an emergency service. Service users 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. There was a procedure in place whereby clinicians would contact the on-call paediatrician at a service user's A&E department to forewarn of an attendance, so suitable preparations could be made. The service did not include prescribing drugs or medication. Nor did it offer referrals to secondary care or arrange testing and imaging.

Clinicians were required to respond to an opening request within ten minutes. The exchanges were not limited in time or length. However, if a service user was seen to be inactive for an hour, the clinician would close the exchange and generate a discharge summary. The feedback we saw and received directly from service users was very positive about their experience of consultations.

Tackling inequity and promoting equality

The service was available to anyone who requested and paid the appropriate subscription fee. We were not told of and saw no evidence of discrimination against any client groups. The provider employed both female and male staff allowing service users a choice. Although the service was based on an English language text exchange, there was a diverse clinical staff group, potentially allowing access for people for whom English was an addition language.

Managing complaints

Information about how to make a complaint was available on the provider's website. However, we noted the process differed from the governance policy document we were shown during the inspection. The provider told us after the inspection that this had been corrected.

No complaints had been made in the two months since the service was registered. However, we saw there was provision for any that were submitted to be actioned, investigated and responded to appropriately. The process allowed for complaints to be submitted by email, but also included a telephone number for a person to person discussion, if preferred. The process set out appropriate timescales for dealing with a complaint and included provision for matters to be escalated to an independent adjudicator.

Good

Are services responsive to people's needs?

Complaints would also be monitored by the registered manager and be reviewed at meetings and knowledge sharing sessions so that learning points could be identified, and improvements made.

Consent to care and treatment

The service provided advice and support to people aged over-18 years old. All clinicians had received training relating to the Mental Capacity Act 2005. Staff understood and service users' consent, where applicable, in line with legislation and guidance.

Requires Improvement

Are services well-led?

We rated well-led as Requires improvement because:

Current system data security measures restricted senior clinicians' access to service users' records limiting full clinical oversight. Information relating to clinical discussions was recorded outside the service app, meaning the service users' records were not always complete. Some governance documentation required review, amendment and implementation.

Business Strategy and Governance arrangements

The provider's staff told us there was a clear vision to work together to provide a high-quality responsive service that put caring and patient safety at its heart. This was confirmed by the provider's detailed business plan, which we reviewed as part of the inspection.

The provider had a clear organisational structure and staff were aware of their own roles and responsibilities. However, we noted some discrepancies, contradictions and errors in the provider's policy documents. For example, in most of the policies the registered manager was responsible for monitoring training, but in the business plan this was stated to be the clinical lead. Others included the safeguarding policies which needed updating to record the respective leads; there were a number of the policies mentioning and cross-referencing other governance papers, which seemingly did not exist, such as the recruitment, training and clinical audit policies; some policy documents referred to legislation which was of no relevance to the service; the complaints process in the policy document differed from that set out on the provider's website. We discussed the matter with the provider's staff. A set of draft governance and policy documents had been obtained commercially, in preparation for registration with CQC. However, they had not been fully reviewed and amended to be appropriate and specific to the service. Although most of the important governance provisions were covered to some extent within the existing documents and clinician's service guidance handbook, it was agreed that more work was required to review, amend and consolidate the policies for them to be wholly effective. The provider told us after the inspection of its plans to conduct the policies review.

There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. These were discussed at a range of regular management, clinical and staff meetings, which included knowledge sharing sessions. A risk register was maintained. There were checks in place to monitor the performance of the service, with some records reviews and technical evaluation. However, the opportunity for full clinical monitoring and auditing was limited due to the current design of the system, the security access rights for the lead clinician and senior clinical staff, and some records - exchanges between the first responder and duty consultant - being stored outside the Juno service app.

Leadership, values and culture

The provider had an effective leadership structure, comprising expertise in business, technical and clinical aspects of the service. There was a lead clinician, whose duties including responsibility for safeguarding issues. A registered manager was in place, although the role was shortly to be transferred to a colleague; both were doctors. The registered manager was accountable for general oversight of the service, but some of the governance policies were unclear or conflicting in their descriptions of roles and responsibilities. There were systems in place to ensure sufficient clinical cover for consultation exchanges was maintained.

The provider had an open and transparent culture. We were told that if there were unexpected or unintended safety incidents, the provider would give affected service users reasonable support, truthful information and a verbal and written apology. This was supported by the provider's duty of candour policy and reference to the duty in the provider's risk assurance policy.

Requires Improvement

Are services well-led?

All staff were involved in discussions regarding the service and how it might be developed and improved. Those we spoke with were enthusiastic and very positive regarding the service and the provider's teamworking ethic. Staff were encouraged to raise matters including concerns at meetings so they could be reviewed, learned from and addressed. Senior managers were clear on ensuing staff wellbeing was sustained. The provider had policies covering bullying and harassment and staff grievance procedures.

Staff appraisals were scheduled for September 2021 and would involve the 360-degree process, to include confidential, anonymous feedback from the people who work around them.

Safety and Security of Patient Information

Service users' records were kept securely and remained confidential. There were policies and IT systems in place to protect the storage and use of all patient information and to identify how and by whom it was accessed. The provider was registered with the Information Commissioner's Office. There were business contingency arrangements in place to minimise the risk of losing patient data, and for it to be maintained and be accessible to service users should the provider cease operating.

Seeking and acting on feedback from service users and staff

Service users were asked to provide feedback after each consultation exchange. This was monitored and if it fell below the provider's agreed standards, it would trigger a review of the consultation to address any perceived shortfalls. The process was limited to an extent by the current security access rights of the lead clinician. However, the provider told us the issue would be addressed with further development of the service system in the near future. Feedback from users was also published on the service website. In addition, users provided feedback and reviews of the service on the Apple App Store website. We saw these were very positive - 192 reviews, with an overall rating of 4.9 out of 5.

Clinicians provided their own feedback at the end of each duty shift, covering clinical and technical aspects. This was monitored and reviewed at staff meetings involving clinical and technical staff to identify if system development was needed.

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 Registered Manager was the named person for dealing with any issues raised under whistleblowing, although the policy made clear concerns could be raised with any manager or director.

Continuous Improvement

From our discussions we found the provider to be receptive and willing to improve in all aspects of the service.

The provider's business plan stated:

- *Juno is a novel paediatric service, which we believe, will directly reduce the need for face to face consultations for Midwifery, Paediatric patients and Paediatric A&E attendances, at a critical time.*
- *Our vision is to offer reassurance and family-centred care in a fast-paced world, where the physician adapts to the patient's needs. We aim to deliver care in an entirely new way.*
- *Juno is a messaging app offering instant reassurance and advice to the paediatric population, their carers and their parents. Juno allows parents and carers to get a specialist opinion directly from a Paediatrician of Midwife without delay.*

Requires Improvement

Are services well-led?

The system had undergone testing and improvement before the provider was registered with CQC. Since then further development had taken place following internal reviews of feedback from service users, clinical staff conducting the consultations and from IT technicians. We saw minutes of meetings which confirmed there was ongoing regular discussion and involvement from staff at all levels. Clinical staff also worked within the NHS and were able to engage with other service providers to help monitor the effectiveness and advantages of the service.

There was a quality improvement strategy and plan in place to monitor quality and to make improvements, for example, through clinical audit. Although that particular means was currently limited due to records access issues, additional development of the service system was planned to allow full and effective auditing, which would drive further improvement.

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
Treatment of disease, disorder or injury Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems and processes must be established and operated effectively to ensure good governance in accordance with the fundamental standards of care.** How the regulation was not being met: • There were processes to monitor performance of the service, but these were limited due to senior clinical staff having restricted access to records, preventing full and effective assessment, monitoring, review and clinical auditing. • We could not establish that all service users' records were complete as in some cases information, such as any exchange between the first responder and consultant, was recorded outside the main Juno service system. • Governance policy documents had not been sufficiently reviewed and amended to be appropriate and specific to the service. Some contained discrepancies and errors. **This was in beach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**