Medical Solutions Inspired

Inspection report

Inspired
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Date of inspection visit: 25 June 2019
Date of publication: 23/08/2019

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?	**Requires improvement**
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. We previously inspected Medical Solutions Inspired on 19 April 2018. The full comprehensive report on the April 2018 inspection can be found by selecting the 'all services' link for Medical Solutions Inspired on our website at www.cqc.org.uk.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection at Medical Solutions Inspired on 25 June 2019. During our previous inspection in April 2018 we found the service was not meeting the standards of the regulations for Safe, Effective and Well led services and we did not have enough information to make a judgement on Caring services. The purpose of this inspection was to follow up the requirement notices we issued following our last inspection in April 2018; and in accordance with our updated methodology to inspect all key questions and provide a quality rating.

Medical Solutions Inspired provided telephone, video and online GP consultations to eligible members of various organisations across the UK. Member organisations offered their clients or employees (and sometimes their family members) the ability to book consultations by phone or online (via mobile phone apps and dedicated websites) 24 hours per day and for 365 days a year. Consultations could be by telephone or video and were unlimited in their duration.

At this inspection we found:

- The service had good systems to manage risk so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes.
- The service routinely reviewed the effectiveness and appropriateness of the care it provided, although we found gaps in documentation and record keeping in patient notes, which did not always reflect or identify guidance used or decision making processes.
- We saw evidence of monitoring in the form of clinical guardian reviews and downloads of prescribing data. The provider could not provide evidence of structured quality improvement activity or effective cycles of audit which focussed on clinical processes. The provider had recently recruited a Chief Medical Officer to support this.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- Patients could access care and treatment from the service within an appropriate timescale for their needs.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- 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).

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a CQC National Advisor in a GP Specialist Advisor capacity and a CQC medicines optimisation team inspector.

Background to Medical Solutions Inspired

Medical Solutions Inspired was established in 1998 and moved to their current premises in 2017. They offer 24 hour, seven days a week telephone and video GP consultations to employees and clients of membership organisations from across the United Kingdom and Ireland. Where eligible, the service will treat children and family members of clients.

Eligible members are offered a dedicated telephone number and access via a mobile app and website. All requests for GP consultations (whether by telephone or through the app) are handled by a dedicated customer service team who are based at the main office complex in Bracknell, Berkshire. Eligible members can request a call back via telephone or video consultation. The online app and website also offer access to health advice, health monitoring and fitness areas.

The organisation is overseen by a Chief Executive Officer and General Manager, with a Managing Director, Medical Advisors and Finance and Operations Director offering day-to-day management of the service. The provider had recently recruited a Chief Medical Officer. There are various department and organisational managers and team leaders supporting IT, customer service, marketing, quality, client development, operations and HR departments.

There are a number of individual GPs who work for the service. The GPs are on the General Medical Council (GMC) GP Register and on the NHS England National Performers List and work remotely to provide patient consultations. They are supplied with a laptop and an encrypted access code to log into the IT server. The customer service call centre is operated by 23 call centre staff, a Customer Service Manager and Call Centre Supervisor.

The service is registered with the Care Quality Commission (CQC) as an Independent Healthcare Organisation. The provider is Medical Solutions UK Limited. The registered office is in Upper Berkley Street in London.

We inspected the main operations offices at the following address:

Medical Solutions Inspired, Inspired, Easthampstead Road, Bracknell, Berkshire, RG12 1YQ

The provider had an arrangement with an external pharmacy service to provide prescribed medicines to eligible clients. The service provided an electronic prescription to the pharmacy who then requested payment from the client directly and arranged to send the medicine to the clients preferred address.

How we inspected this service:

Before the inspection we gathered and reviewed information from the provider. During this inspection we spoke to the Registered Manager, Services Manager, Chief Medical Officer, Clinical Advisor and members of the management and administration team.

The pharmacy aspect of the service was not inspected as part of this inspection as pharmacy organisations are outside the scope of CQC.

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?

At our previous inspection in April 2018, we found the service was not meeting the requirements of the regulations in providing safe services and issued a requirement notice in relation to concerns with safeguarding training, missing recruitment file documentation, no health and safety assessment or training for homeworking GPs, no monitoring of prescribing of high-risk medicines or antibiotics and no identified significant events. We also recommended that the service should have processes in place to confirm the location of patients at the time of contact/consultation.

At this inspection, 25 June 2019, we found the service had addressed the issues identified at the last inspection.

We rated safe as Good because:

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

Keeping people safe and safeguarded from abuse

All staff had access to the safeguarding policies and where to report a safeguarding concern. Patient locations were from across the United Kingdom (including Ireland) and the service used web searches to identify the local safeguarding team if they were required to make a referral. One of the managers was compiling a list of local area safeguarding teams to enable quick access to safeguarding teams across the United Kingdom and Northern Ireland.

The safeguarding lead had been trained to level three for children's safeguarding and had oversight of safeguarding referrals, with the support of the Chief Medical Officer and Medical Advisors. The safeguarding lead was unaware of the up to date safeguarding children intercollegiate guidance document which was published in January 2019.

We reviewed staff training records and found all staff had received safeguarding children training to the appropriate level. Staff we spoke with on the day were aware of their responsibilities, the signs of abuse and how to raise a concern.

All staff had received adult safeguarding training. The selection of GP training records we reviewed showed they had undertaken suitable safeguarding training and the certificates retained in their files. It was a requirement for the GPs registering with the service to provide evidence of up to date safeguarding training certification.

Staff employed at the headquarters had received training in whistleblowing.

The service did treat children and had policies in place for ensuring identity and parental responsibility.

Monitoring health & safety and responding to risks

The provider headquarters was located within modern offices which housed the IT system, call centre and a range of administration and operational staff. Patients were not treated on the premises as GPs carried out the online consultations remotely; usually from their home. All staff based in the premises had received training in health and safety including fire safety. To reduce the risk of staff illness through hot desk working arrangements, the provider had also offered all non-clinical staff infection control training. This involved hand hygiene training and information on cleaning of equipment to prevent transfer of infections between call centre personnel.

The provider expected that all GPs would conduct consultations in private and maintain patient confidentiality. Each GP used an encrypted, password secure laptop to log into the operating system, which was a secure programme. GPs were required to complete a home working risk assessment to ensure their working environment was safe. The provider attended the GPs home to get the IT and telephone equipment set up and check the room selected was suitable and private.

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

A range of clinical and non-clinical meetings were held with staff, 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, for example improvements to the consent policy, a significant incident and clinical pathways in line with national guidance.

Staffing and Recruitment

Good

Are services safe?

There were enough staff, including GPs, to meet the demands for the service and there was a rota for the GPs. There was a support team available to the GPs during consultations and a separate IT team. The prescribing doctors were paid on a sessional basis.

The provider had a selection and recruitment process in place for all staff. There were a number of checks that were required to be undertaken prior to commencing employment, such as references and Disclosure and Barring service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.) For non-clinical staff, there was a policy in place to ensure they were supervised, in circumstances where they were waiting for their DBS check to clear.

Potential GP recruits had to 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 an up to date appraisal and certificates relating to their qualification and training in safeguarding and the Mental Capacity Act. The provider arranged medical indemnity cover for all clinical personnel and some GPs had also provided evidence of their own professional indemnity cover.

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 successfully completed several test scenario consultations.

We reviewed five recruitment files which showed 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 staff including the GPs and there was a system in place that flagged up when any documentation was due for renewal such as their professional registration. The service had also introduced a workstation assessment for homeworking GPs to ensure they were working safely from home and had set up their workstations appropriately.

Prescribing safety

The provider had risk assessed the services prescribing formulary, which had resulted in the number of medicines recommended for prescribing to be reduced. The formulary limited the prescribing of controlled drugs, high risk medicines, or medicines liable to abuse or misuse. If GPs prescribed outside of the formulary they were expected to document the reasons in the patient's clinical records.

The provider had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance. For example, by prescribing from a limited list of antibiotics which was based on national guidance.

If a medicine was deemed appropriate following a consultation, GPs generated a private prescription within the care records system. The service's preferred community pharmacy accessed these prescriptions remotely and contacted the patient to organise a payment. The medicines were then sent to the patients preferred address. All the prescriptions had a GP e-signature which had been verified by the pharmacy. They were unable to generate any prescriptions which required a written signature.

Some of the records we reviewed did not contain information to confirm if the GPs had provided relevant instructions to the patient regarding when and how to take the medicine, the purpose of the medicine and any possible side effects. The monitoring of patient records through clinical guardian reviews had not identified this information.

The service permitted the prescribing of medicines for unlicensed indications. If a GP prescribed a medicine off license, they were expected to inform the patient and document the reasons in the patient's clinical records. (Medicines are given licenses after trials have shown they are safe and effective for treating a particular condition. Use of a medicine for a different condition that is not listed on their license is called unlicensed and is a higher risk as less information is available about the benefits and potential risks).

The service was not designed to offer care to patients with a long-term condition, which required monitoring, or as an emergency service. We were told GPs would make a decision about prescribing in these circumstances and would refer the patient back to their own NHS GP where appropriate to do so.

Information to deliver safe care and treatment

Good

Are services safe?

On registering with the service, and at each consultation patient identity was verified. Eligible clients had a unique identity number from the organisation they were employed by or were a member of. This identity number was given at the point of contact to ensure who it related to. We saw evidence when a number was not recognised by the provider computer system and the call was redirected. The service received a majority of one-off consultations and where there had been previous contacts, the GPs had access to patient's previous records held by the service.

The provider had stipulated what the records layout should be to support appropriate record keeping. Some of the records we reviewed did not contain enough detail to assure us that the information needed to deliver safe care and treatment was recorded by the GPs or were accessible.

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. There had been 27 identified incidents or events since the last inspection. We reviewed six incidents and found that these had been fully investigated, discussed and as a result action taken in the form of a change in processes. For example, email contacts were automatically deleted following an incident where an email was sent to an incorrect recipient.

We reviewed staff meeting minutes and saw significant events were a rolling agenda item. These were discussed, and learning shared with relevant staff. The customer service team also had a white board which was used to share learning and information.

We saw evidence from one incident which demonstrated the provider was aware of and complied with the requirements of the duty of candor by explaining to the patients involved, what went wrong, offering an apology and advising them of any action taken.

The service had a system for receiving and disseminating medicines and patient safety alerts. One of the managers had signed up to receive alerts from the Medicines and Healthcare Products Regulatory Agency. All alerts were discussed at clinical meetings and information relating to medicines were added to the computer system, so an alert was attached to the medicine at the point of prescribing. This allowed the GP to review if it was the correct medicine to prescribe for the patient.

Requires improvement

Are services effective?

At our previous inspection in April 2018 we found the service was not meeting the requirements of the regulations and issued a requirement notice in relation to inconsistent recording of GP training no processes in place to identify if the required training (such as safeguarding) had been undertaken. There was also a lack of assessment of the risks from working from home, and no health and safety assessments or training had been offered to GPs to support them in their home working environment. There was also no formal auditing processes or quality improvement activity to drive improvements in patient outcomes.

At this inspection, 25 June 2019, we found the service had addressed most of the issues identified at the last inspection. They had commenced some monitoring of prescribing, but did not have an effective programme of clinically focused audit cycles or quality improvement activity to demonstrate effective outcomes.

We rated effective as Requires improvement because:

The service routinely reviewed the effectiveness and appropriateness of the care it provided, although we found some gaps in documentation and record keeping in patient notes. The provider had commenced monitoring of some areas of prescribing and had recently recruited a Chief Medical Officer to oversee this.

Assessment and treatment

We were told that each GP assessed patients' needs and delivered care in line with relevant and current evidence-based guidance and standards, including National Institute for Health and Care Excellence (NICE) evidence-based practice. The provider told us their prescribing consultations were attributable to approximately 6% of the total number of consultations. We reviewed 16 medical records, which all included a record of prescribing. Ten records contained information relating to evidence-based assessments and had utilised suitable guidance. However, there were six records where there was limited, or no record of the guidance or structured assessment followed. This included four records with no documentation of the assessment carried out relating to a history of asthma or asthma type symptoms in patients, which resulted in a prescription for an inhaled medicine or oral steroid medicines (such as the ones used in treating asthma). A lack of assessment or not following guidance for recommending such medications could put patients at risk as they require routine review and, often, follow up.

We were told that each telephone or video consultation was allocated to last for a specific duration. The average telephone consultation was within this timeframe. All patients were advised their appointment call would be made within 15 minutes of their allocated appointment time. This offered GPs some flexibility if their consultation overran or was completed earlier than expected. The provider had a dashboard to monitor call length and could reallocate calls to another GP if there was concern over consultation appointments not being dealt with at the appropriate time.

Eligible members were automatically registered by the membership organisation and their details, including medical history, was taken at first contact by the GP. There was a set template to complete for the consultation that included the reasons for the consultation and the outcome to be manually recorded, along with any notes about past medical history and diagnosis. We reviewed 16 medical records which were complete records. GPs had access to any previously recorded notes. We found the majority (10 records) had adequate notes recorded. In the remaining six records, we found the patients NHS GP was not always documented and consent (or no consent) to share the prescribing record with the NHS GP was not contained in the written documentation. In addition, there was no written documentation to support the GP decision to continue to prescribe without sharing with the NHS GP, which was not in line with service policy.

The GPs providing 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 patients. They worked carefully to maximise the benefits and minimise the risks for patients. We were told if a patient needed further examination they were directed to an appropriate agency, although we found one example in the records where a face to face assessment would have been best practice, but this was not suggested to the patient.

Quality improvement

The service monitored consultations and carried out individual GP consultation reviews (including consultations

which had resulted in prescribing) to improve patient outcomes. GPs were encouraged to review and listen back to their consultations and reflect on them. We reviewed a clinical performance summary carried out between January 2019 and May 2019 and found 98% had been reviewed to have met the standards set by the service. The 2% that did not were highlighted to the relevant GPs for reflection and learning. Themes and trends from the performance reviews were shared with other GPs at clinical meetings for wider learning. For example, a reminder was given to GPs to document they had asked patients about any known allergies or contra-indications before prescribing any medications.

The provider prescribed Class 4 and 5 controlled opiate medicines such as codeine. They had restrictions on prescribing of opioids which did not include high potency medicines, such as morphine. (Opioids are a group of medicines that are used for pain relief and require monitoring and review to prevent misuse, abuse or addiction). We were shown the results of a review of prescribing of opioids by the service. The review demonstrated a reduction in the prescribing of opioid medications between June 2018 and May 2019, but did not demonstrate how this had improved quality or effectiveness. There were no other clinically focussed audits or reviews of medicines groups which demonstrated an improvement in quality.

We noted the clinical guardian reviews had not identified some areas of the service policy that were not being adhered to, such as consent to share records with the NHS GP for all prescriptions generated. The provider told us they would review this arrangement after the inspection and in consultation with the Chief Medical Officer, who was new in post.

Staff training

The provider had arranged training bundles to be provided by an external online training company. The bundles allowed non-clinical staff to access the essential training which included safeguarding children and adults, conflict resolution, consent, communication, equality, diversity and human rights, fire safety, health and safety, infection prevention and control, information governance and moving and handling. The service manager did not hold an overarching training record and we were told they reviewed the staff training regularly by viewing individual staff records. We reviewed a sample of staff training records and found they were up to date and had completed all the required training (as determined by the service).

The GPs registered with the service received specific induction training prior to treating patients. This included a course on telephone triage and consultation e-skills. An induction log was held in each staff file and signed off when completed. Supporting material was available, for example, a GPs' handbook, how the IT system worked and aims of the consultation process. There was also a newsletter sent out when any organisational changes were made. The GPs 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.

Administration staff received regular performance reviews. All the GPs had to have received their own appraisals before being considered eligible at recruitment stage. The service had recently recruited a Chief Medical Officer to oversee and review performance of the GPs, including a review of any appraisal or revalidation work.

Coordinating patient care and information sharing

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

We were told all patients who were offered a prescription (for any medicine), were asked for consent to share details of their consultation with their registered NHS GP. GP details were also requested on each occasion a patient used the service. Where patients agreed to share their information, we saw evidence of emails sent to their registered GP in line with GMC guidance. If a patient did not give consent, the service policy for prescribing stated there should be a clear record of the GPs decision to prescribe (or not). We found some records where this policy had not been adhered to.

We reviewed 16 medical consultation records (that included generating a prescription) and found 11 records had consent to share with the NHS GP and 12 records had

Requires improvement

Are services effective?

the NHS GP details recorded. The remaining records had not documented the GP decision to continue to prescribe without consent to share, which was not in line with the service prescribing policy."

Medical Solutions Inspired offered advice if a specialist opinion was appropriate or required consideration (for example, a musculo-skeletal opinion). Where required, an open, private referral letter to a specialist was generated. The patient was able to use this letter should they wish to contact a specialist of their choosing. These were not routinely followed up as the nature of the recommendation was to offer patients an alternative option to their care and treatment and not for any acute or urgent issues. Patients then had the choice to pursue the specialist opinion or not. If a patient required an urgent or acute referral, they were advised to contact their own NHS GP or attend the Emergency Department (where appropriate).

Supporting patients to live healthier lives

Eligible members had access to a dedicated website and mobile app. There was a range of information on healthy living, health conditions, health monitoring and fitness which could be accessed by clicking on the appropriate area of the app or website.

Good

Are services caring?

At our previous inspection in April 2018 we found we did not have enough information available to make a judgement about caring, due to a lack of patient feedback to enable us to determine if the provider was caring.

At this inspection, 25 June 2019, we found the service had addressed the issues identified at the last inspection and had commenced the collection of patient feedback.

We rated caring as Good because:

The provider had requested patient feedback and had identified themes and trends. Patient feedback was mostly positive about the service.

Compassion, dignity and respect

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

The Care Quality Commission (CQC) received feedback from 10 patients who had used the service, via an online feedback form. There were eight positive and two mixed views. All were positive about the service and accessibility. The two mixed comments praised the service overall whilst stating some minor concerns about GP knowledge and listening ability.

We did not speak to patients directly on the day of the inspection. However, we reviewed the latest survey information. The provider had commenced collecting patient feedback in March 2019 and had collated the survey information for the inspection team and had identified some actions to respond to concerns and issues raised. For example, managing patient expectations of the service.

Patients were emailed and offered the opportunity to provide feedback in a number of ways. For example, via an online form or through the patient facing app. They could also telephone the call centre and provide feedback via the customer service team. Many patients reported they felt cared for and were treated with dignity and respect. Some patients reported negatively about GP attitude.

Involvement in decisions about care and treatment

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

The service had an internal performance target to offer a consultation within a set timeframe, after the initial call to book the appointment had been made. Patients could request GP gender of their choice, but choice of a GP's specialty, if any, was not available.

Patient feedback had been formally requested by the provider since May 2019. The collated feedback for May 2019 demonstrated 90% of patients who had used the service, found the clinician helpful and felt they had addressed their health concerns.

Patients could request a copy of their video or telephone consultation notes and recording in line with data protection laws.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

Patient feedback was mostly positive, and the provider responded appropriately to complaints or issues.

Responding to and meeting patients' needs

Telephone and video consultations were available 24 hours a day, seven days a week. This service was not an emergency service. Patients who had a medical emergency were offered immediate medical help via 999 or, if appropriate, to contact their own GP or NHS 111.

The digital application allowed people to contact the service from abroad, but all medical practitioners were required to be based within the United Kingdom. The provider had specifically recruited the majority of their GP workforce from the Thames Valley Area. Any medications prescribed were delivered by the dedicated pharmacy to the address of the patient's choice.

Patients were able to access the service on a mobile phone or other devices (iPhone or android versions that met the required criteria for using the app). The service offered flexible appointments to meet the needs of their patients.

The provider made it clear to patients what the limitations of the service were.

Patients requested an online consultation with a GP and were contacted at the allotted time. We were told that GPs were able to contact the patient back within 15 minutes of their appointment time, which allowed flexibility of the appointment if they required additional time to make an adequate assessment or give treatment advice. The average GP consultation was within the allocated call duration timescale. The provider was able to view call times in real time, through a service dashboard, and could re-assign a call to another GP if an appointment was outside the allotted timescales.

Tackling inequity and promoting equality

The provider offered consultations to anyone who requested it and had been verified as being associated with an eligible member organisation. They 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. The provider told us they could not offer GPs with a specific qualification, due to the service call back timescales and complexity of the GP rota. Type talk was available.

Managing complaints

Information about how to make a complaint was available on the service's patient facing web site and mobile app. The provider had developed a complaints policy and procedure. The policy contained appropriate timescales for dealing with the complaint. There was escalation guidance within the policy. A specific form for the recording of complaints has been developed and introduced for use. We reviewed the complaint system and noted that comments and complaints made to the service were recorded. We reviewed five complaints out of 28 received in the past 12 months.

The provider was able to demonstrate that the complaints we reviewed were handled correctly and patients received a satisfactory response. There was evidence of learning as a result of complaints, changes to the service had been made following complaints, and had been communicated to staff. We were shown a presentation that had been made to the GPs during a clinical meeting, which identified the themes and trends from the complaints over the preceding 12 months. Staff training and reflection on calls was encouraged in response to complaints received regarding staff attitude.

Consent to care and treatment

There was clear information on the service's website with regards to how the service worked, 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 or business organisation could contact them with any enquiries. Charges for the service were paid for by the membership organisation and no fees were directly collected from patients. Prescription charges were paid by the patient to the external pharmacy company who received the prescription and arranged to dispense and deliver the prescribed items.

All GPs had provided evidence of receiving training about the Mental Capacity Act 2005. The provider would offer training to GPs if they were unable to provide certificates or had not received and update. Staff understood and sought patients' consent to care and treatment in line with legislation and guidance. When providing care and

Good

Are services responsive to people's needs?

treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP assessed the patient's capacity and, recorded the outcome of the assessment. The process for seeking consent was not monitored through audits of patient records.

Good

Are services well-led?

At our previous inspection in April 2018 we found the service was not meeting the requirements of the regulations for providing well led services. We issued a requirement notice in relation to the governance arrangements which had not identified documentation gaps in staff recruitment files or a lack of established audit and monitoring processes to drive quality improvement. In addition, they had not established a system for identifying and reviewing patient safety alerts.

At this inspection, 25 June 2019, we found the service had addressed some of the issues identified at the last inspection, although clinically driven audit cycles or quality improvement activity was not effective.

We rated well-led as Good because:

The provider had systems and processes in place to monitor and review service delivery and strategy. They had recruited a Chief Medical Officer to oversee quality improvement and effectiveness of clinical processes.

Business Strategy and Governance arrangements

The provider told us they had a clear vision to work together to provide a high-quality responsive service that put caring and patient safety at its heart. We reviewed business plans that covered the next five years and noted plans to extend the remit of the service and expand. The recruitment strategy supported the current membership size and number of consultations. For example, GPs were recruited through recommendations and "word of mouth".

There was a clear 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.

From the 16 patient records we viewed, we noted the governance arrangements had not identified the gaps in documentation relating to prescribing decisions in the absence of the NHS GP being recorded or if consent had been requested to share these. This was not in line with the service's own policy for prescribing. We also found some records had limited documentation and did not always reflect GP assessments, lines of questioning or records of how a decision was reached prior to offering a prescription. Due to computer system limitations, we were unable to see or review patient records where a decision not to prescribe had been made.

There had been limited audits or quality improvement activity to improve patient outcomes. We were shown data which demonstrated prescribing of a specific group of medicines had reduced over a 12-month period. The provider had established a formulary of antibiotic prescribing which had restricted GP choice of antibiotics inline with national guidance.There were no clinically focussed audits or other quality improvement activity to demonstrate how prescribing was effective. For example, the opioid audit had demonstrated a reduction in prescribing overall, but the provider could not demonstrate they had reviewed the prescribing of these medicines against set standards or to monitor if they were prescribed in line with guidance. The provider had recruited a Chief Medical Officer who would be reviewing this arrangement and identifying areas for action.

There were a variety of daily, weekly and monthly checks in place to monitor the performance of the service. These included random reviews of consultations (clinical guardian). We noted the results of the clinical guardian checks was used to produce a clinical report that was discussed at team meetings and learning was shared with all the GPs.

There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. The provider had established a process for identifying and reviewing information relating to medicine and patient safety alerts, and had taken suitable action, when necessary.

Leadership, values and culture

There was a clear management and organisational structure. The Chief Executive Officer and general manager had overall responsibility for the service and there were three Medical Advisors and a newly appointed Chief Medical Officer who had responsibility and oversight of any medical issues arising. A mixture of clinical and organisational leaders attended the service daily, including at weekends and overnight.

The service vision was to provide safe, high quality 24/7 primary care services to everyone, anytime, anywhere. The service mission was to offer ease of access to GP services with or without technology and putting the patient first. The provider had a number of core values underpinning the vision and mission statements. These included being

Good

Are services well-led?

open and honest, flexible, tailored, caring and compassionate, reliable, responsive, available and accessible and supportive. Trusted doctors and patient satisfaction were also key values.

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

Care and treatment records were securely kept, although the provider could not show us evidence they had an arrangement in place to securely transfer patient records to a third party in the event the provider ceased trading.

Seeking and acting on feedback from patients and staff

The provider had commenced requesting patient feedback in March 2019. They had collated the information received and had commenced analysing the results to determine any actions or responses required. The service had asked patients six questions and the results showed high satisfaction from patients. For example;

- 93% of patients felt their overall experience of the service was good, very good or excellent.
- 98% of patients rated the appointment booking process as good, very good or excellent.
- 77% of patients felt they had saved time using the service (instead of visiting their own GP).
- 88% of patients rated the service as 8, 9 or 10 out of 10.

There was evidence that the GPs could 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.

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 Finance and Operations manager was the named person for dealing with any issues raised under whistleblowing.

Continuous Improvement

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

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

Staff told us that the team meetings were the place where they could raise concerns and discuss areas of improvement. Clinical meetings with GPs were held twice yearly and the Medical Advisors and Chief Medical Officer met quarterly. Monthly management meetings and weekly customer service meetings were held to ensure staff remained up to date. However, as the management team and IT teams worked together at the headquarters there was ongoing discussions at all times about service provision.

There was a strategy and plan in place to continue to monitor quality, improve performance and commence clinically driven audit cycles. The provider had recruited a Chief Medical Officer to support this.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met… There were some systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. However, these were inconsistently applied. In particular: • A programme of clinically driven audit cycles and/or quality improvement activity was not in evidence. • Documentation of decision making processes and guidance utilised within patient records was inconsistently recorded and did not demonstrate appropriate monitoring or oversight. • Service prescribing policy was inconsistently applied and there was no oversight or monitoring of consent to share with patient NHS GP. Not all patient records (where prescribing was an outcome) had captured the NHS GP details.