

Medical Solutions UK Limited

Medical Solutions Inspired

Inspection report

Medical Solutions Inspired
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Overall summary

We carried out an announced comprehensive inspection at Medical Solutions Inspired on 19 April 2018. We undertook this inspection as part of our inspection programme of independent health care providers.

Medical Solutions Inspired provides GP telephone consultations to eligible members of various organisations across the UK. Member organisations offer their clients, employees (and sometimes their family members) a 24 hour telephone service and access to a mobile phone app and dedicated website.

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

Are services safe? – We found that this service was not providing safe care in accordance with the relevant regulations. Specifically:

- Arrangements were in place to safeguard patients from abuse.
- We found the lead for safeguarding was not trained to the appropriate level and the provider had not ensured all GPs had received safeguarding training or checked competence.
- Individual GP prescribing and performance was reviewed regularly, but prescribing audits had not been carried out.

- Suitable numbers of staff were employed and there was a recruitment process in place.
- We found recruitment files for GPs had some documents missing and induction records were inconsistently recorded and retained.
- Most risks were assessed and action taken to mitigate any risks identified, although the provider had not identified any significant events or incidents that had affected the service.

Are services effective? - We found that this service was not providing safe care in accordance with the relevant regulations. Specifically:

- Following patient consultations information was appropriately shared with a patient's own NHS GP in line with GMC guidance.
- There was evidence of an audit program but it did not drive quality or improve patient outcomes.
- Non-clinical staff received the appropriate training to carry out their role.
- The provider relied on GPs receiving appropriate training from their NHS employment and requested their certificates of safeguarding training to confirm this had been undertaken. However, no other training certificates were requested and the provider did not have a process to check clinician knowledge or understanding.

Summary of findings

Are services caring? – We did not have enough information about this service to establish if they were providing a caring service in accordance with the relevant regulations. We have been unable to form a judgement on caring.

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

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

Are services well-led? - We found some areas where the service was not providing a well-led service in accordance with the relevant regulations. Specifically:

- The service had clear leadership and governance structures.
- A range of information was used to monitor the quality and performance of the service, although audits were tailored to individual performance and not used to drive quality improvement.
- Patient information was held securely, although the provider had no arrangements in place to securely transfer patient notes if they ceased to trade.

The areas where the provider should make improvements are:

- The safeguarding lead should receive safeguarding training at an appropriate level for their role.
- Review the arrangements for confirming the location of the patient at the time of the consultation taking place.
- Actively seek the views of stakeholders, including patients using the service, to specifically identify where improvements or changes to patient care may be required.

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

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.

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

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found some areas where the service was not providing a safe service in accordance with the relevant regulations.

Are services effective?

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

Are services caring?

We did not have enough information about this service to establish if they were providing a caring service in accordance with the relevant regulations. We have been unable to form a judgement on caring.

Are services responsive to people's needs?

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

Are services well-led?

We found some areas where the service was not providing a well-led service in accordance with the relevant regulations.

Medical Solutions Inspired

Detailed findings

Background to this inspection

Medical Solutions Inspired was established in 1998 and moved to their current premises in 2017. They offer 24 hour, seven days a week online GP services 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 offers 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. There are various department and organisational managers and team leaders supporting IT, customer service, marketing, client development, operations and HR departments.

There are a number of individual GPs who work for the service. The GPs are also employed as NHS GPs and work

from home. They are supplied with a laptop and an encrypted access code to log onto 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 registered office is in Upper Berkeley Street, London.

We inspected the main operations offices at the following address:

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

We reviewed documents and information relating to eligible members within England only as part of this inspection as our regulatory powers are restricted to England. The service has not been inspected before.

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

Are services safe?

Our findings

Our findings

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

Keeping people safe and safeguarded from abuse

Staff employed at the headquarters had received training in safeguarding and whistleblowing and knew the signs of abuse. All staff had access to the safeguarding policies and where to report a safeguarding concern. Patient locations were from across the United Kingdom (including Northern Ireland) and the service used web searches to identify the local safeguarding team if they were required to make a referral.

The safeguarding lead was trained to level two child safeguarding and was due to undertake level three. GPs and non-clinical staff had access to a Medical Supervisor who was a GP trained to level three for safeguarding and the provider could access support and information from an external consultancy agency with level four safeguarding. All GPs were required to show evidence of adult and level three child safeguarding training prior to commencing their contract with the service. However, not all GPs had shown their safeguarding training certificates and the provider had no alternative systems in place to review safeguarding competence or offering their own training. The service treated children and family members of some eligible patients. The provider told us after the inspection, they were continuing to request evidence of safeguarding training undertaken by GPs and were looking at alternative training options they could offer.

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 the patient's confidentiality. Each GP used an encrypted, password secure laptop to log into the operating system, which was a secure programme. GPs had not been asked to complete a home working risk assessment to ensure their working environment was safe and had not been offered health and safety training specific to the service. The provider had included a home working assessment and health and safety training to the GP induction documentation and showed us evidence these had been commenced after the inspection.

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. The provider did not have systems in place to ensure the location of the patient at the beginning of the consultation was known, so emergency services could be called if an emergency did occur. The service told us they would review this arrangement after the inspection.

The service had a clinical risk assessment and management policy outlining the agreed limitations of the service and what actions to follow in the event a service user requested outside these restrictions. GP calls were monitored for quality assurance and discussed with the individual GPs for reflection and appraisal.

A range of clinical and non-clinical meetings were held with staff, where standing agenda items covered topics such as 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 changes to the prescribing policy and clinical pathways in line with national guidance.

The provider had liaised with the landlord of the office complex which hosted their call centre and operations centre, to ensure all risks associated with the building had been mitigated. We saw evidence of various risk assessments and surveys including legionella, asbestos and fire safety checks. The provider did not show the

Are services safe?

inspection team their own fire risk assessment on the day of the inspection, but we were shown a copy (dated August 2017) after the inspection. The provider told us they had carried out a fire drill but were unable to show us any evidence to support this on the day of the inspection. We were shown a fire drill record dated January 2018 after the inspection. We did see evidence that regular checks of emergency lighting, fire extinguisher servicing and fire alarm systems was carried out by the landlord.

Staffing and Recruitment

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 and Medical Advisors available to the GPs during consultations and a separate IT team.

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

Potential GP 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 were offered professional indemnity cover by the provider which included cover for video consultations.

We reviewed five GP and three non-clinical staff recruitment files and found not all the necessary documentation was available. The provider told us GPs could not be registered to start any consultations until these checks and induction training had been completed. However, we found three GPs had commenced their contract without suitable references and there were no induction records available in the five GP files we viewed to confirm they were supported during their induction period and ensure all processes had been covered. We were shown a blank checklist form used for GP inductions and the provider had developed a new GP induction document which was due to be introduced in the next few weeks.

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 requested GPs to provide up to date appraisal and certificates relating to

their qualification and training in safeguarding. The provider had recently commenced requesting GPs provide certificates of Mental Capacity Act training and were unable to show us evidence of this training for the five selected GP recruitment files.

Prescribing safety

The service monitored patient records to review compliance with prescribing which were then discussed with the clinician. There was also a review of trends in medicines prescribed although this was not formally audited. We did see evidence of prescribing GPs prescribed individually and there was a general formulary available on the service computer records system, although it was unclear if this aligned to the national agenda for prescribing. We noted there was no antibiotic formulary for GPs to use and there were no audits of antibiotic prescribing to monitor and prevent antimicrobial resistance. A sample of patient records we viewed did show that appropriate antibiotics had been prescribed. The provider policy for prescribing ensured that a prescription could not be generated without informing the NHS GP of the consultation and outcome. If a patient refused to give consent, the prescription was not issued.

If a medicine was deemed necessary following a consultation, the GPs were able to issue a private prescription to an external pharmacy company who collected the appropriate payment from the patient and distributed the medicine by post to them. Once the GP prescribed the medicine and dosage of choice, relevant instructions were given to the patient regarding when and how to take the medicine, the purpose of the medicine and any likely side effects and what they should do if they became unwell.

We noted some controlled drugs had been prescribed, such as medicines for anxiety. There had been no auditing of these or other high risk medicines to monitor their use, although the service was considering implementing these checks in the future. There were computer system alerts to highlight medicines that were at risk of being misused and GPs had access to client records to view previous consultations.

The provider encouraged GPs not to provide repeat medicines or to prescribe for long term conditions.

Are services safe?

However, when repeat supplies of medicines were prescribed, there was a clear record of the decisions made and the service contacted the patient's regular GP to advise them.

We did not see any evidence of off-label or unlicensed medicines being prescribed. (Medicines are given licences after trials have shown they are safe and effective for treating a particular condition. Use of a medicine for a different medical condition that is listed on their licence is called unlicensed use and is a higher risk because less information is available about the benefits and potential risks). The provider told us they would refer a client back to their NHS GP in the first instance, if an unlicensed medicine was requested. There was a policy to offer verbal information to patients if an unlicensed medicine was prescribed although we noted there was no additional written information available to guide the patient when and how to use these medicines safely.

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

All prescriptions were dispensed and delivered direct to the patient by an external pharmacy company. The service had a system in place to assure them the prescription had been received, paid for and the medicine dispensed.

Information to deliver safe care and treatment

On registering with the service, and at each consultation patient identity was verified. As the service was business to business, eligible members accessed the service via a dedicated telephone number or mobile phone app. The call centre staff could identify which organisation the caller was from and then identify them from a list of known employees or members for that organisation. GPs verified the patient name and address and had access to the patient's previous records held by the service.

If a child was being treated, the service checked the eligible members ID (including if the child was on the agreed list of associate members) but did not have checks in place to verify if the eligible member had parental/guardian responsibility for the child.

Management and learning from safety incidents and alerts

There were systems in place for incident reporting. The provider told us they had no reported incidents in the preceding 12 months. However, we found there had been occasions when situations had been identified and actioned but not escalated as a significant event. For example, the provider had only recently identified they needed to review patient safety and medicines alerts and had not raised this as a significant event. We also noted the provider had relocated to the current premises in July 2017 and completed the move in September 2017. This event had not been formally documented, reviewed or discussed to identify learning from the event or identify any risks occurring from the relocation.

As there were no incidents identified, reviewed or actions taken, we could not evidence how learning was shared or if an analysis of trends was undertaken. We did receive feedback from staff on how the provider communicated with them through email, staff meetings and noticeboards in the call centre.

The provider was aware of and complied with the requirements of the duty of candour.

The provider had only recently considered reviewing patient safety and medicines alerts. They had started the process of signing up for alerts from the Medicines and Healthcare Products Regulatory Agency.

Are services effective?

(for example, treatment is effective)

Our findings

Our findings

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

Assessment and treatment

We reviewed examples of medical records that demonstrated that GPs 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.

We were told that each telephone or video consultation appointment 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 the 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 or Medical Advisor if there was a 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 medical records which were complete records. We saw that adequate notes were recorded and the GPs had access to all previous notes.

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. If a patient needed further examination they were directed to an appropriate agency. If the provider could not deal with the patient's request, this was explained to the patient and a record kept of the decision.

Quality improvement

The provider had a responsive audit program of individual GP consultations and monthly monitoring of key performance indicators. However, the audits we viewed did not review clinical processes or identify learning to promote patient outcomes and quality improvement. For example, the provider had not proactively reviewed prescribing of high risk medicines or antimicrobials.

The service monitored GP and customer service key performance indicators as part of their individual performance reviews. For example, GPs routinely received a review of their performance and the process of consultations. Calls were selected at random from the preceding month's consultations and reviewed for various aspects of the call including history taking, prescribing processes and safety. Each element was marked and a judgement made as to whether the call was exceeding expectations, meeting expectations or "for reflection". The calls deemed for reflection were shared with the GP involved who reviewed the call themselves. We saw evidence that 3% of all GP consultations were reviewed between April 2017 and March 2018. Of these, 1% required reflection and further review. The reflections were used to improve individual performance and was not shared for general learning.

The provider also considered patient complaints and feedback to inform on quality of performance.

Staff training

All customer service staff had to complete induction training which consisted of adult and child safeguarding, health and safety, fire safety, infection control, information governance, consent and person-centred care. Staff also had to complete other training such as whistleblowing, conflict resolution, equality and diversity and red flags for patient care. Following the induction period, customer service staff were also assessed on their competency in call handling and general operations. The project and operations manager had a training matrix which identified when training was due.

New GPs employed by the service had to receive specific induction training prior to treating patients, although an induction record was not available in GP staff files to identify when they had completed their induction and what had been covered. GPs were expected to show evidence of their safeguarding training prior to commencing their contract and no specific training (such as health and safety

Are services effective?

(for example, treatment is effective)

or Mental Capacity) was routinely offered to GPs by the provider. As all the recruited GPs were currently working in NHS services (as GPs) the provider had an expectation for them to have been offered the training with their other employers. However, there were no checks to confirm they had received training or when updates were due.

A staff handbook was available to all staff. 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 training.

Administration staff received regular performance reviews. All the GPs had to have received their own appraisals before being considered eligible at recruitment stage. Regular performance reviews of GP consultations ensured compliance with call standards and staff were offered the opportunity to reflect on calls for their own revalidation and reflection.

Coordinating patient care and information sharing

During client consultations (and where relevant) patients were asked if the details of their consultation could be shared with their registered GP. If patients agreed we were told that a letter was sent to their registered GP in line with General Medical Council (GMC) guidance.

Medical Solutions Inspired did not offer specialist referrals to patients. They would offer advice if a specialist opinion was appropriate or required consideration (for example, a musculo-skeletal opinion). Where required, a letter was generated offering the advice of a specialism for the patient to consider. 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).

The provider did not offer a diagnostic testing service but could receive test results from third party services for patients to have the results reviewed and discussed.

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.

In their consultation records we found patients were given advice on healthy living as appropriate.

Are services caring?

Our findings

Our findings

We did not have enough information about this service to establish if they were providing a caring service in accordance with the relevant regulations. We have been unable to form a judgement on caring.

Compassion, dignity and respect

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

The provider did not have direct contact with patients as the contractual arrangement was business to business. The provider requested member organisations to collate feedback from eligible members about the provision of the medical service. We were shown some survey information that had been gained by one of their member organisations. The information was not available to the public and we were unable to publish it.

The provider had not undertaken any of their own patient survey or feedback exercises to establish if the care and treatment they provided was of a satisfactory standard. A

lack of established feedback did not enable the provider to review the service they offered and make improvements. The provider told us they were considering a post consultation questionnaire to gain patient satisfaction in the future and were looking at how this could be enabled through their current technology and software.

We were unable to speak to any patients on the day of the inspection.

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.

Patients had access to information about the GPs working for the service and could book a consultation with a GP of their choice. For example, whether they wanted to speak to a male or female GP or a GP with a specialist interest. Some of the GPs available could speak a variety of different languages.

We were unable to determine patient satisfaction with being involved in decisions about their care as the information we were shown was from a member organisation who had undertaken a contractual satisfaction survey and the provider had not established their own source of patient feedback.

Patients could have a copy of their video or telephone consultation only if they made a written request for a copy of the recording to the provider.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Our findings

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

Responding to and meeting patients' needs

GP 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 advised to ask for 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 GPs 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 prescriptions issued were delivered within the UK to the patient's home/address of choice.

Patients were able to access the service on a mobile phone, tablet 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. The average GP consultation was within the allocated call duration timescale and the provider could re-assign a call to another GP or Medical Advisor if an appointment was outside the allotted time.

Tackling inequity and promoting equality

The provider offered consultations to any eligible members who requested one and did not discriminate against any client group.

Patients could access a brief description of the GPs available. Patients could choose either a male or female GP or one that spoke a specific language or had a specific qualification. Type talk was available.

Managing complaints

Information about how to make a complaint was available on the service's web site. The provider had developed a complaints policy and procedure. The policy contained appropriate timescales for dealing with the complaint. There was escalation guidance within the policy. A specific form for the recording of complaints has been developed and introduced for use. We reviewed the complaint system and noted that comments and complaints made to the service were recorded. We reviewed three complaints out of 40 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.

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 could contact them with any enquiries. Charges for the service were paid by the membership organisation and no fees were directly collected from patients. Prescription charges were paid by the patient to the pharmacy company who received the prescription and arranged to dispense and deliver the prescribed items.

Non clinical staff had received training about the Mental Capacity Act (MCA) 2005. Staff understood and sought patients' consent to care and treatment in line with legislation and guidance. GPs were assumed to have received the training through their NHS work, although the provider had only recently begun to request evidence of this. GPs we spoke with understood the principles MCA. When providing care and 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

Are services responsive to people's needs?

(for example, to feedback?)

unclear the GP assessed the patient's capacity and, recorded the outcome of the assessment. The process for seeking consent was not monitored or audited by the provider.

Are services well-led?

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

Our findings

Our findings

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

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 there were plans to extend and expand the service. The recruitment strategy supported the current membership size and number of consultations. For example, GPs were recruited through recommendation and “word of mouth”.

The arrangements for recording and maintaining staff recruitment files and training records had not been monitored or reviewed to ensure competence and compliance. We saw gaps in five GP recruitment files and in the training matrix we observed six GPs without evidence of adult safeguarding and four GPs without evidence of child safeguarding.

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.

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

The arrangements for identifying, recording and managing risks and issues was inconsistently applied. For example, the provider had not identified significant events or incidents that had affected the service, such as, reviewing patient and medicine safety alerts or identifying the risks and learning outcomes associated with moving premises in 2017.

The provider did not show the inspection team their own fire risk assessment on the day of the inspection, but we were shown a copy (dated August 2017) after the inspection. The provider was unable to show us evidence of fire drills being undertaken. After the inspection, we were sent a fire drill record from January 2018 which highlighted actions to be taken but did not detail if these had been actioned or completed.

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

Leadership, values and culture

There was a clear management and organisational structure. The general manager had overall responsibility for the service and three Medical Advisors had responsibility for 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 focus 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 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

Are services well-led?

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

minimise the risk of losing patient data. However, the provider did not have the necessary arrangements in place to securely transfer the records to a third party in the event the provider ceased trading.

Seeking and acting on feedback from patients and staff

The provider did not seek direct feedback from patients. They were considering offering a feedback survey to be sent to eligible patients following a consultation and were looking at various ways this could be achieved (for example, by text or email). Examples of patient case studies were available on the service website.

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

Staff at the premises could offer feedback to the provider through meetings, appraisal, general discussion and a suggestions board. They were also encouraged to write on a white board their achievements and where they had excelled or exceeded in their role. The white board was promoted as a morale boosting exercise for staff working at the call centre. The information was not routinely collected or kept for future reference and reflection. Following the inspection, the provider told us they had undertaken a staff survey in May 2018 to gain further staff feedback.

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 Director 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. As the GPs worked for NHS providers, the service had access to a diverse range of ideas and suggestions, and encouraged innovations.

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 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 monitor quality and performance and the provider was considering using clinical audit to make improvements to patient outcomes.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation 12: Safe Care and Treatment</p> <p>How the regulation was not being met:</p> <p>The provider had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:</p> <ul style="list-style-type: none">• Significant events were not identified or reported appropriately to mitigate risks.• There was limited monitoring or oversight of prescribing. In particular, high risk medicines, controlled drugs and antimicrobials. <p>This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Transport services, triage and medical advice provided remotely	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>Regulation 17: Good governance</p> <p>How the regulation was not being met:</p> <p>There were inconsistent systems or processes that enabled the provider to assess, monitor and improve the quality and safety of the services being provided. In particular:</p> <ul style="list-style-type: none">• The established audit program was not driving quality or improving patient outcomes.• Systems for identifying and reviewing patient and medicines safety alerts had not been appropriately established or fully embedded.

This section is primarily information for the provider

Requirement notices

- Recruitment files had documentation missing (relating to schedule three) and induction records were inconsistently recorded and retained.

This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

Transport services, triage and medical advice provided remotely

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18: Staffing

How the regulation was not being met:

The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular:

- Training records for GPs did not ensure they had the necessary training to support them in their role and the provider had not considered the risks associated with working from home or established a suitable training system to support their health and safety at work.

This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.