Medic Spot Limited

Medicspot HQ

Inspection report

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Date of inspection visit: 30 November 2017
Date of publication: 27/02/2018

Overall summary

Letter from Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Medicspot HQ (known as MedicSpot) on 30 November 2017.

Medicspot is a new service operating from the website: www.medicspot.co.uk. The service functions as an online GP practice providing pre-booked video consultations with patients in clinical stations based in pharmacies.

We found this service provided safe, effective, caring, responsive and well led services in accordance with the relevant regulations.

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

Are services safe? – we found the service was providing a safe service in accordance with the relevant regulations. Specifically:

- Arrangements were in place to safeguard people, including arrangements to check patient identity.
- Prescribing was in line with national guidance, and people were told about the risks associated with any medicines used outside of their licence.
- Suitable numbers of staff were employed and appropriately recruited.
- Risks were assessed and action taken to mitigate any risks identified.

Are services effective? - we found the service was providing an effective service in accordance with the relevant regulations. Specifically:

- Following patient consultations, if they consented, information was appropriately shared with a patient's own GP in line with GMC guidance.
- Quality improvement activity, including clinical audit, took place.
- Staff received the appropriate training to carry out their role.

Are services caring? – we found the service was providing a caring service in accordance with the relevant regulations. Specifically:

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

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

- Information about how to access the service was clear and the service was available 7 days a week.
- The provider did not discriminate against any client group.

Summary of findings

- Information about how to complain was available and complaints were handled appropriately.

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

- The service had clear leadership and governance structures
- A range of information was used to monitor and improve the quality and performance of the service.
- Patient information was stored securely.

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 that this service was providing safe care in accordance with the relevant regulations.

Are services effective?
We found that this service was providing effective care in accordance with the relevant regulations.

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

Are services responsive to people's needs?
We found that this service was providing responsive services in accordance with the relevant regulations.

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

Medicspot HQ

Detailed findings

Background to this inspection

MedicSpot is a new service which functions as an online video-linked GP service. The GPs work remotely providing pre-booked video consultations with patients who are based in a private clinical station in their selected pharmacy. MedicSpot use online technology to enable patients to book a consultation with a GP at one of the participating pharmacies throughout the country. The video consultation allows the doctor to see and speak to the patient via a video link at the pharmacy clinical station and the equipment provided allows the patient to perform specific observations including pulse rate, blood pressure and temperature.

Clinical stations comprise a computer and an equipment tower which includes a blood pressure machine and cuff; a stethoscope (to listen to heart and lungs); a flexible medicam (to look into the throat and ears); a pulseoximeter (to measure oxygen levels and pulse rate) and a thermometer. Instruction is provided on how to use the equipment and the patient informs the GP of the readings taken.

The service is operated by the CEO (chief executive officer) who is also the registered manager. (A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run). The CEO is supported by the Medical Director who shares responsibility for the operational and clinical management of the service. Both the CEO and Medical Director are GPs.

The service employs four members of staff, three GPs and one administrator all of whom work remotely.

Consultations can be booked between 9am and 6pm daily dependent on the opening times of individual pharmacies and the availability of GP appointments. Access via the website to book a consultation is available 24 hours a day.

How we inspected this service

Our inspection team was led by a CQC Lead Inspector accompanied by a GP Specialist Adviser and a member of the CQC medicines team.

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew.

During our visit we:

- Spoke with the CEO, Medical Director, GPs and participating pharmacists.
- Reviewed organisational documents.
- Reviewed patient consultation records.

To get to the heart of patients' experiences of care and treatment, we always 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.

Why we inspected this service

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Are services safe?

Our findings

We found that this service was providing safe care in accordance with the relevant regulations.

Keeping people safe and safeguarded from abuse

GPs employed by the service had received training in safeguarding both adults and children relevant to their role and knew the signs of abuse and to whom to report them. All the GPs had received level three child safeguarding training and adult safeguarding training. It was a requirement for the GPs registering with the service to provide safeguarding training certification. All staff had access to safeguarding policies and could access information about who to report a safeguarding concern to.

The service offered treatment to children over 5 years. Photographic identification was required for patients under 18 and for both the parent/guardian and child at the beginning of any consultation with a child.

Monitoring health & safety and responding to risks

All clinical consultations were assessed by the GPs for risk. For example, if the GP thought there may be serious mental or physical issues that required treatment they were unable to provide they were able to discontinue the consultation and arrange a refund of the fee paid by the patient.

All risk assessments were discussed at the daily debriefing and regular clinical meetings. There were protocols in place to notify Public Health England of any patients who had notifiable infectious diseases.

The provider headquarters were located in the home office of the CEO and the administrative support staff work remotely. Patients were not treated at the HQ premises and GPs carried out their video consultations remotely, usually from their home or office location. Participating pharmacies were responsible for monitoring the health and safety of their own premises.

All clinical stations based in pharmacies were provided with an equipment tower by MedicSpot. This included a blood pressure machine and cuff; a stethoscope (to listen to heart and lung sounds); a medicam (a flexible camera too look into the throat and ears and could be used to focus on other parts of the body as required); a pulseoximeter (to measure oxygen levels and pulse rate) and a thermometer. This equipment was provided by a third party who were responsible for maintenance, repairs and annual calibration. The equipment was cleaned and checked by the pharmacy staff between patients.

The provider expected that all GPs would conduct consultations in private to maintain the patient's confidentiality. Each GP used their 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 made policies available to employees regarding appropriate management of IT systems, including confidentiality issues and encryption policies. There was also an IT business continuity plan in place to deal with IT emergencies.

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 regular 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 manage the situation. We were shown an example where the GP had assessed that urgent care was required and appropriate action had been taken.

Staffing and Recruitment

There was sufficient staff, including GPs, to meet the demands for the service. There was support available to the GPs from the CEO and Medical Director, both of whom were GPs.

The provider had a selection process in place for the recruitment of staff. Recruitment checks were carried out for all staff prior to commencing employment. GPs had to be working in the NHS, and continue to do so, and be registered with the General Medical Council (GMC) and on the Performers List. All candidates were on the GMC GP register. Relevant documentation was kept on file, including their professional indemnity cover as well as proof of registration with the GMC (or other professional body), proof of their qualifications and certificates for training in safeguarding and the Mental Capacity Act.

GPs had to provide evidence of participating in the GP appraisal scheme (a copy of the most recent appraisal was

Are services safe?

retained in their staff record). A copy of individual professional indemnity cover was kept on record in addition to a copy of the provider's own indemnity cover for the service.

The provider kept records for all staff. We reviewed all four recruitment files which showed the necessary documentation was available. The GPs could not start providing consultations until these checks and induction training had been completed.

Prescribing safety

GPs diagnosed patients' conditions and prescribed treatment according to the clinical need of the patient. If a medicine was deemed necessary following a consultation, the GP issued a private prescription for the patient.

When booking their consultation, patients were required to choose a pharmacy (from a list of participating pharmacies) where they would like their consultation to take place and if required, their prescription dispensed. The dispensed medicines were not included as part of the overall service offered to the patient.

The provider's website included guidance on the type of minor ailments the service was able to treat. There were checks in the system which prevented certain medicines, such as schedule 2 and 3 controlled drugs, being prescribed. These medicines had been assessed by the provider as posing too high a risk to prescribe remotely. Some other medicines with a lower risk profile required additional checks by the doctor before prescribing could take place and limits were put on the amount that could be prescribed.

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

Following agreement to prescribe a medicine. Relevant instructions were given to the patient regarding the correct dosage; when and how to take the medicine; the purpose of the medicine; any likely side effects and what they should do if they became unwell.

When emergency supplies of medicines were prescribed, there was a clear record of the decisions made and with the agreement of the patient the service contacted the patient's regular GP to advise them.

All individual patient consultations were was recorded. GPs could check if patients had accessed the service previously and we saw that this was a necessary step in the process when certain medicines were to be prescribed. We reviewed a sample of patient records and found that they had not been prescribed repeat quantities of medicines inappropriately. Copies of all prescriptions were kept in the patient consultation records and were audited weekly to ensure prescribing was appropriate.

The service prescribed some unlicensed medicines and medicines for unlicensed indications if appropriate. (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). Clear information was given to the patient by the GP to explain that the medicine was being used outside of their licence, and the patient had to acknowledge that they understood this information. Additional written information to guide the patient when and how to use these medicines safely was supplied with the medicine. The patient record system also included a prompt to the GP to alert that they were prescribing an unlicensed medicine to ensure they alerted the patient. We saw evidence where this process was used appropriately.

In order to ensure patients received their medicines as efficiently as possible, copies of the prescriptions issued were sent to the pharmacy immediately on completion of the consultation and followed up with the hard copy. A system was in place to ensure that only one authorised copy of the prescription could be presented and the two pharmacists we spoke with assured us that the system was used effectively by Medic Spot and all prescriptions were correctly reconciled within 72 hours as is required by legislation.

The doctors prescribed to current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) evidence based practice. For example we saw that national guidelines for antibiotic use were followed and the provider had completed a two cycle audit of their antimicrobial prescribing which showed that the doctors were prescribing appropriately. We saw evidence of patients being given supportive therapy and advice rather than a prescription for antibiotics when it was not considered necessary.

Are services safe?

All medicines prescribed to patients following a consultation were monitored by the provider to ensure prescribing was evidence based and safe, for example to identify any form of abuse such as excessive requests.

Information to deliver safe care and treatment

The provider informed us that in line with similar services such as NHS Walk in Centres and Minor Injury Units they did not verify patient identity before a patient is seen through the MedicSpot System. They had undertaken a thorough risk assessment before reaching their decision.

Patients were required to enter their details on the consultation booking form, which included as a minimum: name, date of birth, address, email address or telephone number. At the start of each consultation, the doctor asked the patient to confirm these details to ensure that the correct patient was being seen. Subsequent consultations by the same patient were managed in the same way, that is, the patient was required to enter all of their details again and these would again be checked by the consulting GP. The GP was able to perform a search on all previous contacts with the patient to view previous consultations.

A prescribing policy was in place which stated occasions when GPs must check photographic identification such as, when consulting with children and when prescribing specific medicines with the potential for abuse.

Consultations with children were only undertaken in the presence of a parent or guardian, who were also required to provide photographic identification. GPs were also encouraged to check photographic identity in any cases where they had concerns.

Management and learning from safety incidents and alerts

There were systems in place to deal with medicine safety alerts. The Medical Director was signed up to receive MHRA (Medicines and Healthcare products Regulatory Agency) patient safety alerts and disseminated any relevant information to the doctors and pharmacists as appropriate. They were aware of the most recent alert issued the week of the inspection and had taken appropriate action.

There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. We reviewed the eight incidents that had occurred in the previous 12 months and found that these had been fully investigated, discussed and, if required, action taken in the form of a change in processes. We saw evidence that the provider learned from incidents. For example a doctor prescribed a medicine that had been assessed by the provider as high risk and not appropriate to prescribe remotely. After an investigation additional safeguards were installed into the software program to prevent a reoccurrence.

Quarterly clinical meetings were held via Skype and were attended by all clinical staff. Standing agenda items included discussion of significant events. The provider retained a summary of all incidents in order to identify and analyse trends.Daily debriefing sessions were also carried out between one of the directors and the GP on duty. This enabled any issues or urgent changes and improvements to be identified and considered promptly.

We saw evidence from the incidents we reviewed which demonstrated the provider was aware of and complied with the requirements of the Duty of Candour by explaining to the patient what went wrong, offering an apology and advising them of any action taken.

Are services effective?

(for example, treatment is effective)

Our findings

We found that this service was providing an effective service in accordance with the relevant regulations.

Assessment and treatment

The provider made it clear to patients on the website the limitations and range of minor ailments and travel issues for which they were able to provide a diagnosis, treatment and health advice.

Patients were not required to complete an online consultation form to describe details of the condition or their past medical history. An online form was completed by the patient when booking the consultation appointment but this only required the details of the patient's identity, such name address, telephone number and date of birth. All relevant medical history was obtained during the video consultation and recorded by the consulting GP in the patient's record. This included the reasons for the consultation and the outcome, along with any notes about past medical history and diagnosis. A consultation checklist was available for use by the GP to ensure the consultation procedure was adhered to.

We reviewed 10 medical records which were complete records and adequate notes were recorded. The GPs had access to all previous notes. The examples we reviewed 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 consultations were not time-limited at present. The consultation lasted as long as required to manage the issue presented by the patient. If the GP had not reached a satisfactory conclusion, such as when awaiting test results, a GP would contact the patient again once the results were received. All patients were required to provide an email address or telephone number.

The pre-booked video consultations took place at a clinical station based in a private area in a participating pharmacy. All consultations were recorded free text and allowed the doctor to make a detailed record of the discussions they had with the patient and their diagnosis. In all the records we looked at, a complete medical history had been taken and documented, including any medicines the patient was already taking and any known allergies. An appropriate examination had been carried out using the equipment available and the results documented. This could include temperature, blood pressure, pulse rate, oxygen saturation, heart and lung sounds and observation by small medical camera as was necessary. The doctor recorded a diagnosis and any advice that the patient was given as well as the medicines prescribed. Within these records we saw examples of patients being given appropriate signposting to other services, advice as to their future health, safety-netting advice about how to manage a worsening condition and information about supportive therapy when medicines were not prescribed.

The GPs providing the service were aware of both the strengths (speed, convenience, choice of time) and the limitations (limitations in performing a 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 service. If the provider could not deal with the patient's request, this was explained to the patient and a record kept of the decision.

Quality improvement

The service collected and monitored information on the care and treatment provided. This included information about patients' outcomes and quality improvement activity, such as consultation and prescribing audits to implement appropriate improvements.

Records were kept of individual patient consultations but these did not currently form a continuous patient record. Doctors could check if patients had accessed the service previously and we saw that this was a necessary step in the process when certain medicines were to be prescribed. We reviewed a sample of patient records and found that they had not been prescribed repeat quantities of medicines inappropriately. Copies of all prescriptions were kept in the patient consultation records and were audited weekly to ensure prescribing was appropriate.

Staff told us that they could raise concerns and discuss areas of improvement at any time, including at team meetings. There was a quality improvement strategy and plan in place, for example, through clinical audit, daily debriefing sessions and reviews of patient record reviews.

Staff training

Are services effective?

(for example, treatment is effective)

All staff had to complete induction training when joining the organisation. This included terms and conditions of employment; Health and Safety; Work Duties and Learning & Training Needs. An induction and staff training policy were in place.

GPs had received specific induction training prior to treating patients. An induction log was held in each staff file and signed off when completed. GPs received support if there were any technical issues or clinical queries and could access policies remotely. When updates were made to the IT systems or policies and procedures GPs received updates and training if required.

Administration staff received regular performance reviews. All the GPs had to have received their own GP appraisals before being considered eligible at recruitment stage. GPs had to provide evidence of participating in the GP appraisal scheme (a copy of the most recent appraisal was retained in the staff record). All GPs were required to include reference to their video consultation work in future GP appraisals.

Coordinating patient care and information sharing

When a patient contacted the service they were asked if the details of their consultation could be shared with their registered GP. If patients agreed, a letter was sent to their registered GP in line with GMC guidance. We saw a number of examples where patients had been encouraged to consent to MedicSpot sharing information with their own GP. The report sent to the GP was comprehensive and detailed. We were told that if the GP felt it was important that information was shared with the pateint’s own GP they would actively encourage the sharing of information, and if refused would consider if treatment was still appropriate.

We also saw examples of MedicSpot liaison with other services to ascertain test results and sharing of additional information in order to determine appropriate management and treatment options. The GP on duty each day would check for any test results and action appropriately.

Supporting patients to live healthier lives

The service identified patients who may be in need of extra support and were able to signpost them to appropriate services (or links to NHS websites or blogs). In their consultation records we found patients were given advice on healthy living as appropriate.

Are services caring?

Our findings

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

Compassion, dignity and respect

We were told that the GPs undertook consultations in a private room and were not to be disturbed at any time during their working time.

We did not speak to patients directly on the day of the inspection. However, from the patient feedback we reviewed we saw that patients were satisfied with the way they were treated and prompt action was taken in response to negative comments. For example, one comment had been received regarding the poor soundproofing in a consultation room and this was fully actioned by the provider.

At the end of every consultation, patients were sent an email asking for their feedback. The provider received a 90% response rate with all responses being positive about the care received. Negative comments related only to issues with connectivity and unfamiliarity with the use of the equipment.

The stations where patients were able to access the video service were situated in pharmacy consultation rooms. We spoke with two pharmacists who confirmed that these were private rooms where patient confidentiality could be maintained. If patients needed help with any of the equipment they were able to call a member of the pharmacy staff to support them. Between consultations the equipment was cleaned and checked for the next patient.

Involvement in decisions about care and treatment

Patient information guides about how to use the service and technical issues were available on the website. Patients could contact the service by email but there was no telephone contact number available.

Patients had access to information about the GPs working for the service but could not book a consultation with a GP of their choice.

The latest survey information indicated that patients were satisfied with the service they received. All negative comments were reviewed, analysed and actions for improvement identified and implemented.

Video consultations were not recorded but patients could have a copy of their consultation record emailed to them if requested.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting patients' needs

Patients carried out a booking to arrange a video consultation appointment with a GP and were required to attend the appropriate pharmacy at the allotted time where they were shown to a private room containing the clinical station. There were no set time limits for a consultation.

Consultations could be booked between 9am and 6pm daily. However, this was also dependent on the opening times of individual pharmacies and the availability of appointments. Access via the website to book a consultation was available 24 hours a day. The 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 go to the Accident and Emergency Department (A&E) or NHS 111.

We saw appropriate examples of patients directed to emergency services. For example, a patient visiting the country on holiday presented with gastroenteritis symptoms and, despite looking well, observations carried out via the clinical station showed that they had a very low blood pressure and a rapid pulse rate. The GP liaised with the pharmacist who printed off the consultation notes for the patient and arranged transport to take the patient to A&E. Follow up communication with the patient confirmed that they were retained in hospital for 24 hours to undergo intravenous therapy and made a full recovery.

The provider made it clear to patients on the website what the limitations of the service were and consulting GPs explained fully to patients if they felt it was inappropriate to provide treatment. We saw examples of patients being refunded the consultation fee when the GP felt it was inappropriate to prescribe medicines demanded by a patient. When the provider could not deal with the patient's request, this was explained to the patient and a record kept of the decision.

Patients were asked to complete a post-consultation feedback form immediately after the consultation.

The majority of feedback was positive but the provider reviewed all negative comments and identified actions for each issue raised in order to improve the service. The most common theme for negative feedback was problems with internet connectivity. The provider was closely monitoring this and was in the process of assessing the feasibility of switching to mobile broadband as a back-up for locations which were consistently receiving complaints of poor speeds.

Tackling inequity and promoting equality

The provider offered consultations to anyone who requested and paid the appropriate fee, and did not discriminate against any client group.

Patients could access a brief description of the GPs available. Patients were not able to choose a specific GP.

Managing complaints

Information about how to make a complaint was available on the service web site. The provider had developed a complaints policy and procedure. The policy contained appropriate timescales for dealing with complaints. A link was available on the website for the reporting of complaints. We reviewed the complaint system and noted that comments and complaints made to the service were recorded and action taken where appropriate. We reviewed the four complaints 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 and what costs applied including a set of frequently asked questions for further supporting information. The website had a set of terms and conditions and details on how the patient could contact them with any enquiries. Information about the cost of the consultation was known in advance and paid for when booking the appointment online. The costs of any resulting prescription were handled by the pharmacy when the prescription was dispensed.

GPs understood and sought patients' consent to care and treatment in line with current legislation and guidance. All GPs had received training on the Mental Capacity Act 2005.

Are services responsive to people's needs?

(for example, to feedback?)

When providing care and treatment for children and young people, GPs 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 recorded on patient records.

Are services well-led?

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

Our findings

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

Business Strategy and Governance arrangements

The provider told us they had a clear vision to provide a high quality responsive service that put caring and patient safety at its heart. We reviewed their business plan that covered the next five years. This was comprehensive and included details of finance, operations and strategies for development.

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 working remotely. These were reviewed and updated when necessary.

There were arrangements in place for identifying, recording and managing risks, issues and implementing mitigating actions. There were a variety of regular 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 team report that was discussed at team meetings. This ensured a comprehensive understanding of the performance of the service was maintained and highlighted any areas for improvement.

The CEO or Medical Director carried out a debriefing call at the end of each day with all GPs to discuss any concerns, incidents or patient follow-up required.

Leadership, values and culture

The CEO (chief executive officer) of the company had overall responsibility for the service and shared the operational and clinical management of the service with the Medical Director, both of whom also provided weekly GP sessions for the service. They attended the service daily and there were systems in place to address their absence.

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

The provider and staff were clear about the values of the service which included an overarching aim to provide convenient, high-quality and safe healthcare by employing the potential in the use of medical technology to improve patient care. The service was currently only available from pharmacy settings where MedicSpot GPs had access to examination facilities but they had plans to expand the service in the future.

The service had an open and transparent culture. 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 and evidence we saw at the inspection.

Safety and Security of Patient Information

All GPs were required to log into the patient record system using a two factor authorisation token. Systems were in place to ensure that all patient information remained 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 complete, accurate and securely stored. They were only available to staff with appropriate access authorisation.

Seeking and acting on feedback from patients and staff

The majority of feedback was positive but the provider reviewed all negative feedback and identified an action for each issue raised in order to improve the service. The most common theme for negative feedback was problems with internet connectivity. The provider was closely monitoring this.

Patients could rate the service they received. MedicSpot asked all patients to complete a post-consultation feedback immediately after the consultation. This has resulted in an average response rate of 90%. This was constantly monitored and if negative feedback was received, this would trigger a review of the consultation or

Are services well-led?

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

issue raised in order to address any shortfalls. In addition, there was a link on the provider's website for patients to provide feedback. Patient feedback was published on the service's website.

There was evidence that the GPs were able to provide feedback about the quality of the operating system and requests for changes were discussed at clinical team meetings and decisions made for 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 CEO was the named person for dealing with any issues raised under whistleblowing.

Continuous Improvement

The service consistently sought ways to improve. Incidents and good practice cases were analysed and presented at clinical meetings to ensure learning and the development of the service. For example information about the importance of sharing information with the patient's own GP was added to the patient form after a doctor had two consultations with a patient who may have suffered an allergic reaction to antibiotics.

All staff were involved in discussions about how to develop the service and were encouraged to identify ways to improve the service delivered. We saw minutes of staff meetings where previous interactions and consultations were discussed.

Staff told us that they could raise concerns and discuss areas of improvement at any time including at team meetings. There was a quality improvement strategy and plan in place to monitor quality and to make improvements, for example, through clinical audit, daily debriefing sessions and reviews of patient records.