MyMed Ltd

Q doctor

Inspection report

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Q doctor on 23 August 2018 as part of our inspection programme.

Q doctor is an online GP consulation service which allows patients to consult with a GP via video link. Patients can access the service via their own device and can either pay a single consultation fee or pay an annual subscription to the service, which allows them access to a specific number of consultations throughout the year. The service is also available in some pharmacies (which Q doctor has a contract with) where patients can either request an appointment or where pharmacy staff will suggest the service to them in cases where the patient requires a medicine which needs to be prescribed; in which case they will pay for a video consultation, which will be carried-out it a private room at the pharmacy. The service also provides an online GP locum service, whereby GP practices pay for a locum session with one of the service's GPs, which is carried-out via video link. When Q doctor is delivering the online GP locum aspect of its service, care for patients is delivered under the governance arrangements of the commissioning GP practice, with Q doctor acting as a locum agency; therefore, we did not inspect this aspect of the service.

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.
- 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 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.

Summary of findings

- Patient feedback reflected they found the service treated them with dignity and respect. The service did not display patient feedback on their website.
- Patients were able to select whether they saw a male or female GP; however, the service did not display information about GPs working at the service on their website, to enable patients to make an informed choice about the GP they saw.

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.
- 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 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 held securely.

The areas where the provider should make improvements are:

- Arrange for all GPs working for the service to complete Mental Capacity Act training, as identified in the service's training action plan.
- Publishing Patient feedback on their website.
- Provide information about GPs working for the service on their website, to enable patients to make an informed choice about which GP they choose to consult with.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Q doctor

Detailed findings

Background to this inspection

Q doctor was registered with CQC on 6 September 2017.

Q doctor is an online GP consultation service which allows patients to consult with a GP via video link. Patients can access the service via their own device and can either pay a single consultation fee or pay an annual subscription to the service, which allows them access to a specific number of consultations throughout the year. If a consultation with a doctor results in a prescription being issued, this is sent directly to Q doctor's partner pharmacy, who dispense the medicine and send it by post to the patient. The service is also available in some pharmacies (which Q doctor has a contract with) where patients can either request an appointment or will have it suggested to them by pharmacy staff in cases where they require a medicine which needs to be prescribed; in which case they will pay for a video consultation, which will be carried-out it a private room at the pharmacy. The service also provides an online GP locum service, whereby GP practices pay for a locum session with one of the service's GPs, which is carried-out via video link. When Q doctor is delivering this aspect of its service, care for patients is delivered under the governance arrangements of the commissioning GP practice, with Q doctor acting as a locum agency; therefore, we did not inspect this aspect of the service.

How we inspected this service

This inspection was carried out on 23 August 2018; the inspection team consisted of a CQC Lead Inspector, GP Specialist Advisor and Pharmacist Specialist Advisor.

Before the inspection we gathered and reviewed information from the provider. During the inspection we spoke to the Registered Manager, members of the management and administration team a clinician working for the service and members of staff from one of the pharmacies using the in-pharmacy remote consulting service.

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.

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

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 which detailed where to report a safeguarding concern. All the GPs had received adult and level three child safeguarding training. It was a requirement for the GPs registering with the service to provide evidence of up to date safeguarding training certification.

The service did not treat children; however, staff were aware of the possibility that they could identify child safeguarding issues in the course of their interactions with adults, and therefore, they had a child safeguarding policy in place to support staff in dealing with these issues. The policy contained the contact details for child safeguarding teams at each local authority in the UK.

Monitoring health & safety and responding to risks

The Chief Medical Officer carried out daily reviews of patient consultation records, and the outcomes of these were discussed in weekly clinical meetings.

Monitoring health & safety and responding to risks

The provider headquarters was located within modern offices which housed the IT system and a range of administration 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.

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. The suitability of GPs' home working environment was assessed as part of their induction.

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 either 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 was known at the beginning of the consultation, so emergency services could be called.

At the time of the inspection the service did not have a formal process for rating consultations for risk or triaging appointment requests. As the service was in its infancy, and therefore seeing relatively few patients, all appointment requests from individuals were viewed by the Chief Medical Officer, who was able to alert the consulting doctor of any risk factors or identify if a patient needed more urgent care. Patients seeking an appointment via the pharmacy link were placed into a virtual "waiting room" and were typically seen by a doctor within a maximum of 20 minutes.

If a patient was assessed as requiring face to face medical attention, they were signposted appropriately either to A&E, to their own registered GP, or to a walk-in centre. Where patients were referred to a walk-in centre, the patient records system viewed by the service's consulting GPs had the facility to search using the patient's address to send them an interactive map to direct them to the nearest walk-in centre to them.

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 discussions about significant events and service development discussions, such as discussions about the types of examinations which were appropriate for online consultations.

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 available to the GPs during consultations and a separate IT team. The prescribing doctors were paid on an hourly 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 (for administrative staff) 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.) The service explained that they had made the decision not to request references as part of the recruitment process for clinical staff, as they had found that in most cases previous employers were only willing to confirm the dates that an individual worked for their organisation. The service had assessed that the additional background information available for clinical staff, such as checks against the General Medical Council register, NHS Performers register, and evidence of ongoing GP appraisal and revalidation, provided adequate assurance of potential employees' working history and good character. We saw evidence these checks had been completed for each of the clinical staff working for the service. However, whilst this process was documented in the service's "onboarding" policy for clinical staff, the specific arrangements relating to background checks for clinical staff were not included in the service's general recruitment policy. Immediately following the inspection, the service provided evidence that they had updated their recruitment policy to reflect the process being undertaken, but also undertook to gather references for any clinical staff recruited in future.

The service held a professional indemnity policy, which covered all clinicians who worked for them. One of the terms of this policy was that each individual covered should also hold a professional indemnity policy with one of the three main professional indemnity insurers, covering their work outside of the service; we saw evidence that the service checked that all relevant staff had the necessary indemnity arrangements in place, and that they had systems in place to flag when each GP's own policy was due for renewal so that they would be prompted to check that individuals had renewed their cover. Similar arrangments were in place in respect of each GP's external appraisal and safeguarding training.

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 four 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.

Prescribing safety

All medicines prescribed to patients during a consultation were monitored by the provider to ensure prescribing was evidence based. The service had risk assessed the prescribing of medicines and as a result they had established a list of a limited number of medicines which they felt could safely be prescribed (there were no controlled drugs on the list); the service would only prescribe up to 10 days worth of medicines, apart from in exceptional circumstances, where the clinical rationale would be recorded in the patient's notes. The service's prescribing policy directed GPs to refer to published guidance for advice on the appropriate prescribing of antibiotics; however, it did not indicate what specific guidance. Following discussions about this during the inspection, the service provided evidence that they had updated their prescribing policy and had embedded a link to the Royal College of General Practitioners antibiotic toolkit, which included regional guidance on antibiotic prescribing.

As a further safety measure, the service had set further limitations to the medicines available to be prescribed, where patients did not consent to information about the prescription being shared with their registered NHS GP. Whilst the provider did explain the limitations of the service to patients under the terms and conditions section of their website, this information was not immediately clear, and therefore there was a possibility that a patient might pay for a consultation and then find that the medicine they required was not available via the service. We rasied this issue during the inspection and the service immediately ensured that information about their limited prescribing was displayed more prominently on their website.

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.

There were protocols in place for identifying and verifying the patient and General Medical Council guidance was followed. Patients registering with the service were required to provide photographic ID and the picture was then compared to their image on screen.

For patients consulting with a Q doctor GP via a pharmacy, where a prescription was produced this was sent directly to the pharmacy where the patient was located; the

Are services safe?

prescription was then dispensed directly by the pharmacy. For patients consulting with Q doctor directly, prescriptions were sent directly to the associated pharmacy for dispensing and medicines were sent to the patient by post.

Information to deliver safe care and treatment

On registering with the service, and at each consultation, patient identity was verified. At the time of the inspection the consulting GPs did not automatically have access to the patient's previous records held by the service. As the service was newly established at the time of the inspection and therefore seeing only a small number of patients, both appointment requests and the outcome of consultations were being closely monitored by the chief medical officer (CMO), who was available duing the service's hours of operation (with backup from the chief executive, who was also a clinician). The CMO would review each appointment request and forward to the consulting GP any pertinent information held on the patient from previous consultations with the service. The service was aware that this would not be a tenable arrangement as the service grew, and following discussions about this during the inspection, the service confirmed that they had changed the system to allow GPs to view details of all historical notes when consulting with a patient.

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. We reviewed nine 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, following an incident where a GP had prescribed a medicine which was not on the permitted list of medicines available for GPs to prescribe, we were told that the incident was dicussed with the GP concerned, we also saw evidence that the details of the incident were shared with other GPs in order to raise awareness of the issue, and that members of the clinical leadership team worked with the technical team to amend the prescribing system to prevent it from being overridden.

Are services effective?

(for example, treatment is effective)

Our findings

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

Assessment and treatment

We reviewed six examples of medical records that demonstrated 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.

We were told that each online consultation was scheduled for 20 minutes, but there was no fixed time limit in place and the consultation could continue for longer if necessary.

Patients completed an online form which included their past medical history. There was a set template for consulting GPs to complete for the consultation, which included detils of the reasons for the consultation, the outcome, and any notes about past medical history and diagnosis. We reviewed six medical records which were complete records. We saw that adequate notes were recorded. At the time of the inspection, GPs were unable to access previous records for patients during consultations. We were told that the Chief Medical Officer had access to all historical records held by the service, and that they reviewed all appointment requests, including historical records for the patient, prior to the consultation and flagged any pertinent information, including excessive requests for prescriptions, with the consulting GP prior to the consultation. We discussed the limitations of this system during the inspection, particularly when the service expands and offers a higher volume of appointments. Immediately following the inspection we were informed by the service that they had revised their system to allow all GPs to view a full history for each patient they consult with.

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. The patient records system used by GPs allowed them to search using the patient's address to locate the nearest NHS walk-in centre to the patient and send the patients an interactive map to direct them there. If the provider could not deal with the issues that the patient presented with, this was explained to the patient and a record kept of the decision.

The service monitored consultations and carried out consultation and prescribing audits to improve patient outcomes. Audits including areas such as referrals, and prescriptions of particular medicines were completed by the Chief Medical Officer, and we saw evidence that these were discussed at the Integrated Governance Committee meetings, and Clinical Advisory Group meetings.

Quality improvement

The service collected and monitored information on patients' care and treatment outcomes.

- The service used information about patients' outcomes to make improvements.
- The service took part in quality improvement activity, for example audits, reviews of consultations and prescribing trends. Due to the small number of consultations being carried-out at the time of the inspection, all consultations, including prescriptions issued, were being reviewed by the Chief Medical Officer (CMO). We saw evidence that the CMO then collated prescribing data in order to carry-out an overall review and report on trends.

Staff training

All staff had to complete induction training which consisted of training on the online system and familiarising with the service's policies and procedures. Staff based at the service's offices also had to complete training in health and safety, and fire safety. Clinical staff who worked remotely had to complete on-boarding exercises including working through example clinical scenarios, they also had their home working environment assessed to ensure that it was suitable to maintain patient confidentiality and provide a professional appearance. An induction log was held and clinical staff were not permitted to carry-out consultations until they had completed a full induction.

Staff also had to complete other training on a regular basis including adult and child safeguarding (child level 1 for administrative staff and child level 3 for clinical staff), mental capacity and data security. The service maintained a training matrix which identified when training was due. If any clinical staff failed to keep up to date with required

Are services effective?

(for example, treatment is effective)

training or if other necessary documents (such as professional indemnity certificates) expired, the clinician would be suspended from the service until such time as they completed training or provided the necessary updated documentation. We saw examples of this process being effectively employed.

Staff 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 or to the service's policies, all staff received updates and any necessary further training. A regular newsletter was sent out to clinical staff by email, which outlined any changes or updates. The service also maintained an online "chat" system which allowed staff to communicate with each other in relation to both clinical matters and to get support for technical IT problems.

All staff received regular performance reviews. All the GPs had to provide evidence of having completed their own annual appraisals before being considered eligible at recruitment stage. The service also told us they would be carrying-out in-house annual appraisals for clinical staff. We were unable to view any examples of appraisals during the inspection, as none of the staff working for the service had been in post for a full year at the time.

Coordinating patient care and information sharing

When a patient registered with the service they were encouraged to provide details of their registered GP; the online registration form had an integrated search facility to allow patients to search for their registered NHS GP using their address, this ensured that patients were not prevented from providing their GP's details as a result of them being unsure of the surgery name or address. When the patient booked an appointment with the service they were asked each time whether they consented to the details of the consultation being shared with their registered GP. If patients agreed we were told that a letter was sent to their registered GP in line with GMC guidance. Where patients declined consent, the consulting doctor would explore this further with them, in line with GMC guidance. The service told us that they were in the process of securing a contract with Docman to allow them to share information with patients' registered GPs electronically.

The service did not order blood tests for patients; if blood tests were required in order to treat a patient, they were advised to visit their registered GP or NHS walk-in centre. Referrals could be made by the service to external specialists or services; in which case any resulting correspondence would be sent to the patient's registered GP rather than to Q doctor.

The service monitored the appropriateness of referrals to improve patient outcomes. We viewed the service's audit of referrals, all of which were made via the online locum service, there had been no referrals made via the pharmacy or direct private consultation service.

Supporting patients to live healthier lives

The service identified patients who may be in need of extra support and GPs could signpost patients to sources of advice and information as necessary.

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 video consultations in a private room and were not to be disturbed at any time during their working time. As part of the induction process, the provider checked each GP's working environment to ensure that it was suitable. The service told us they were in the process of arranging to install the facility on GP's computers to allow a still photograph to be taken intermittently, showing the view of consulting GPs that patients would see, in order to allow the service to monitor that GPs were complying with the required standards in respect of consultation location and personal appearance.

We did not speak to patients directly on the days of the inspection. However, we reviewed the service's latest survey information. At the end of every consultation, a pop-up appeared on the patient's screen which allowed them to score the service they received out of five and to submit free-text comments. This feedback was used by the service to provide feedback to the consulting GPs and to make changes where necessary. Any scores of three or under were automatically transferred to the service's complaints spreadsheet to allow for trends to be spotted. We saw evidence that the issues identified were discussed in the quarterly clinical governance meeting. The data provided by the service showed that in the past 12 months, 107 patients had provided feedback within the private service, and of these 103 patients (96%) had provided positive feedback.

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.

At the time of the inspection patients did not have access to information about the GPs working for the service; however, they could book a consultation with a GP of their choice. For example, patients could choose whether they wanted to see a male or female GP. The GPs available could speak a variety of different languages and a language translation service was available to be used for translation where required.

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

Consultations were provided Monday to Friday from 1pm to 5pm; the service had previously offered a broader range of consulting hours, but had reduced the availability of consultation times to the afternoons having found that very few patients required consultations during the morning. The service was open to monitoring patients' requirements in respect of opening times as the service expanded.

Patients could access consultations either directly or via an online link in one of the service's partner pharmacies. The service was advertised in the partner pharmacies, and pharmacists would also give patients the option of using the service if they came to the pharmacy requesting a medicine which was only available with a prescription. Pharmacy staff could access the Q doctor system and search the service's medicines formulary so that they could ensure that the medicine required by the patient was one that Q doctor was able to prescribe prior to the patient paying for a consultation.

If the patient accessed the service directly, having registered and had their ID verified, they could select an appointment time with a GP of their choice. Patients who accessed the service via a pharmacy had to follow the same registration and ID verification process, but were then placed in a virtual "waiting room" and would consult with a GP as soon as one was available; patients were given an estimated wait time when they joined the queue.

This service was not an emergency service. The appointment booking system nominally allocated 20 minutes for appointments; however, we were told that appointments could last as long as was needed. The Chief Medical Officer and administrative staff monitored the appointments system; if a consultation lasted longer than expected, any patients waiting would be contacted and offered to either consult with a different GP or to arrange an alternative time for the consultation.

Patients who had a medical emergency were advised to ask for immediate medical help via 999 or if appropriate to contact their own GP, NHS 111 or an NHS walk-in centre.

The service had the facility to direct patients to their nearest NHS walk-in centre by locating the nearest service using the patient's current location and then sending them an interactive map to direct them.

The provider made it clear to patients what the limitations of the service were. Information on their website explained clearly the types of problems they were able to treat. The service only accepted consultation requests for patients located in the UK.

Tackling inequity and promoting equality

The provider offered consultations to anyone aged over 18 years who requested and paid the appropriate fee, and did not discriminate against any client group.

Patients could choose either a male or female GP.

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. We reviewed the complaint system and noted that comments and complaints made to the service were recorded, this included any patient satisfaction scores of three or below out of five.

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 before the consultation appointment commenced. Patients could either pay for an individual consultation or pay a subscription which allowed them access to the service on a set number of occasions annually for a fixed fee. Where a consultation resulted in a prescription being issued, for

Are services responsive to people's needs?

(for example, to feedback?)

patients consulting with the service directly, payment for medicines was made via the Q doctor portal and the medicines were dispatched to the patient by the service's partner pharmacy. For patients consulting with the service via the in-pharmacy service, prescriptions were send directly to the pharmacy where the patient was located, and payment for the medicines was made by the patient directly to the pharmacy.

All administrative staff had received training about the Mental Capacity Act 2005. GPs had not received this training; however, we saw evidence that the service had identified this as a general training need for all GPs working for the service, and had added this to their action plan. From our interviews with GPs we found that there was a good understanding about issues of mental capacity and that staff understood and sought patients' consent to care and treatment in line with legislation and guidance.

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 work together to provide a high quality responsive service that put caring and patient safety at its heart, and that worked alongside the NHS. We reviewed business plans that covered the next five years, in which the service outlined its plans to increase uptake by patients both directly and via in-pharmacy consultation, and also its ambition to build services to compliment and support the NHS via the provision of its online locum service and providing online consultations for patients contacting the NHS 111 service.

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 and updated when necessary; we saw evidence that staff were alerted when policies were updated, and staff were required to confirm that they had read the updated policy.

There were a variety of daily, weekly and monthly checks in place to monitor the performance of the service. At the time of the inspection the service was fairly newly launched and was only carrying-out a small number of consultations, and therefore the Chief Medical Officer (CMO) was able to review each consultation record; information from these checks was used to provide feedback to GPs in order to make improvements to the service. Feedback was provided via a number of different avenues such as the online "chat" facility, GP newsletter emails, and discussions in meetings. This ensured a comprehensive understanding of the performance of the service was maintained. The service was aware of the need to establish a process of reviewing samples of consultation records should the service expand to a degree where reviewing every consultation was no longer feasible.

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

Care and treatment records were complete, accurate, and securely kept. At the time of the inspection the service did not have arrangements in place to store clinical records in line with legislation should they cease trading; however, they subsequently put arrangements in place to address this.

Leadership, values and culture

The Chief Executive (and founder) of the service was a clinician who had identified that online technology could be used to provide a healthcare system which met the needs of patients and reduce the burden on the NHS. As a result, they had participated in the NHS England clinical entrepreneur training programme, which is a programme designed to offer opportunities for junior doctors develop their entrepreneurial aspirations during their clinical training period. The service's stated aims in its statement of purpose were " to build on the existing clinical evidence for safe and effective use of video technology in medicine, providing patients with a service that is easy to access and ultimately leads to improved patient outcomes".

The Chief Medical Officer (CMO) had responsibility for any medical issues arising; they were a qualified GP, working part-time in active practice within the NHS. They either attended the service's head office or were available remotely daily. The Chief Executive of the service was also a qualified clinician and was able to advise on medical issues in the absence of the CMO.

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. The service's data security systems had been assessed as part of their bid to take part in the NHS 111 service pilot, and we saw evidence that they had received approval from NHS Digital that their systems met the required security standard.

Are services well-led?

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

There were business contingency plans in place to minimise the risk of losing patient data.

Seeking and acting on feedback from patients and staff

Patients could rate the service they received. Patient feedback was constantly monitored; any ratings of three out of five or below were automatically captured on a spreadsheed and reviewed by the management team. From the data we were shown, patient feedback was overwhelmingly positive. Patient feedback was not 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 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 Chief Executive 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 minutes of staff meetings where previous interactions and consultations were discussed.

Staff told us that there were several avenues where they could raise concerns and discuss areas of improvement, such as team meetings and the online "chat" facility. The management team and IT teams worked closely together and there was ongoing discussions at all times about service provision.

There was a quality improvement strategy and plan in place to monitor quality and to make improvements, for example, through clinical audit. The service monitored consultations and carried out consultation and prescribing audits to improve patient outcomes. Audits including areas such as referrals, and prescriptions of particular medicines were completed by the Chief Medical Officer, and we saw evidence that these were discussed at the Integrated Governance Committee meetings, and Clinical Advisory Group meetings.

In addition to plans to develop and expand the business, the service had also identified a number of areas for development in order to make the service safer for patients; for example, they had identified the need to monitor unfulfilled prescriptions, to allow them to follow-up on patients who did not collect the medicines prescribed for them.