Healthsteer Limited

Inspection report

112 Main Street
Dickens Heath, Shirley
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Good
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Overall summary

Letter from the Chief Inspector of General Practice

We rated this service as Inadequate overall.

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Inadequate

Are services caring? – Good

Are services responsive? – Requires improvement

Are services well-led? – Inadequate

We carried out an announced comprehensive inspection at Healthsteer Limited on 13 August 2021 as part of our inspection programme.

Healthsteer Limited is an online GP consulting service. Patients access the service by completing an online form and choose a time for their video/telephone consultation with a GP.

At this inspection we found:

- The service did not have effective systems to manage risks. There was a lack of clear systems for managing incidents, patient safety alerts and complaints to support learning and improvement and mitigate future risks.
- The practice had policies and procedures in place but these were not always service specific, and what we were told was happening was not always evident in the records seen.
- Staff training required by the provider had not been identified or monitored to ensure staff had received that which was relevant and up to date.
- The provider did not have effective systems in place for ensuring safe prescribing or for the sharing of information about consultations with the patients GP where it is in the interests of patient safety to do so.
- The provider did not have effective quality assurance processes in pace to assess the effectiveness and appropriateness of the care it provided.
- Staff treated people with compassion, kindness, dignity and respect.
- Patients could access care and treatment from the service within an appropriate timescale for their needs
- There were effective processes for confirming the identity of patients they consulted with.

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

- 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.

Overall summary

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector**.** The team included a member of the CQC medicines team and a GP Specialist Advisor.

The lead inspector and CQC medicines team inspector undertook a site visit.

The GP Specialist Advisor spoke to staff using video conferencing facilities and completed clinical records reviews without visiting the location.

Background to Healthsteer Limited

Healthsteer Limited is an online GP consulting service. Patients can access consultations by registering with the service via the provider's website. Once registered patients can select a time for their video consultation. The GP will then call the patient at the agreed time. The service is available on a pay as you go basis or by signing up to one of the providers subscription plan arrangements.

The provider is registered with CQC to deliver the regulated activity: Treatment of disease, disorder or injury. The provider registered in May 2019 under the current location at 112 Main Street, Dickens Heath, Shirley, Solihull. B90 1UA. Prior to this, the provider had been registered at a different address in Hall Green, Birmingham. The address in Solihull is the provider's administrative office.

There is a registered manager in place who is also the Managing Director 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 service is managed by the Managing Director (non-clinical) and five founding doctors (who developed the service). The founding doctors are all secondary care consultants with the following specialisms; acute medicine, general medicine, respiratory, orthopaedics and diabetes/endocrinology).

There are five doctors who provide remote consultations with patients (four are GPs and one a doctor specialising in internal medicine). The doctors are all of self-employed status working for the provider as locum GPs (one female and four male). There are three directly employed administrative staff who provider customer service and IT support.

The majority of patients seen were adults however the provider also saw children.

The service is open 8am to 8pm Monday to Friday and 8am to 1pm Saturday and Bank Holidays for appointments.

How we inspected this service

During this inspection we gathered and reviewed information from the provider. We spoke to the Registered Manager, one of the founding consultants, a locum GP and the customer services lead and reviewed a sample of clinical records.

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.

Inadequate

Are services safe?

We rated safe as Inadequate because we identified significant concerns in managing risks relating to patient care and the delivery of the service and to support learning, there was a lack of clear and consistent policies and procedures in place to support staff. In particular, we identified issues in relation to prescribing safety.

Keeping people safe and safeguarded from abuse

The provider did not have adequate safeguarding arrangements in place. The service had safeguarding policies in place and held a list of local authority contacts. Clinicians could contact customer service support if they had a safeguarding concern and to forward any referrals to the relevant safeguarding authority. One of the founding doctors at Healthsteer was the safeguarding lead for the service but this was not reflected in the safeguarding policy. We were told the safeguarding lead was trained to a level three for safeguarding children and adults, however, training records forwarded to us indicated they had only completed level two. There was an expectation that clinical staff had undertaken safeguarding training in their NHS substantive roles, however this was not being verified by the provider. Non-clinical staff including those involved in customer service support had not completed safeguarding training. The provider told us that they had not made any safeguarding referrals or needed to. However, in a clinical record seen there had been no record of any discussion with the parent/guardian to establish why they did not wish the information relating to their child's consultation to be shared with their GP before continuing to treat.

The provider offered consultations with children but there was a lack of consistency and no clear policy about the age ranges of children the provider would see. There was also a lack of clarity as to how many children had been seen by the service, as the service was not easily able to provide this data for us. We were told that both the parent /guardian identity and child's birth certificate were checked on registration when consulting with a child and the provider was able to demonstrate an effective system was in place for checking patient identity.

The provider had a whistleblowing policy should staff needed to report any concerns about the service. However, the policy had not been made service specific to ensure the information was relevant and up to date.

Monitoring health & safety and responding to risks

The provider headquarters was located within a modern office that was predominantly used by administrative staff, although during the COVID-19 pandemic staff had tended to mainly work from home. Patients did not attend the premises as all consultations were online and undertaken by clinicians who worked remotely.

Staff told us that they had covered some in house health and safety training relating to display screen equipment with the managing director. One member of the administrative team told us they had undertaken fire safety training and was the nominated fire marshal for the service. However, fire safety training was not routinely undertaken by staff who used the office facilities. We saw no staff training records relating to fire safety or health and safety. The provider told us that staff were mainly working from home during the pandemic.

The provider expected that all GPs would conduct consultations in private and maintain patient confidentiality. Each GP used an encrypted, password secure system that they accessed from their own computer. GPs were required to complete a home working risk assessment to ensure their working environment was safe.

Staff told us that there were systems for managing risk during clinical consultations. Patients were required to provide information about their past medical history, medicines and allergies prior to the consultation so that the clinician was aware. Patients were unable to register without a telephone number and so they could be contacted if needed.

Inadequate

Are services safe?

Staff told us that consultations automatically ended after 10 minutes with the opportunity for a patient to extend the call for an additional fee after eight minutes but If there were any concerns, the doctor would be able to extend the consultation to ensure appropriate resolution. However, we saw an example where this had not occurred during our review of clinical records and there was no clear guidance for staff as to how this would work in practice. The provider advised us that clinical staff had been trained to use this function and had done so.

We found there was a lack of clear policies and procedural guidance for staff to follow. There was also a disconnect between what the leadership of the service was telling us and what was happening in practice, for example in relation to the management of children, long-term conditions and prescribing of controlled drugs. There was no routine sharing of information with a patients GP when it was in the interest of patient safety to do so.

Staff we spoke with were aware of the need to notify Public Health England of any patients who had notifiable infectious diseases but had not yet needed to do so. Clinical staff could contact the administrative team of any action arising during the consultation that needed follow up.

The provider held regular twice weekly non-clinical meetings with non-clinical staff which focussed on the business side of the service. Monthly, clinical meetings had recently been introduced and there had only been one to date, this gave the clinicians an opportunity to raise any issues arising in their work.

Staffing and Recruitment

There were enough staff, including clinical staff, to meet the demands of the service and there was a rota to ensure there were clinical staff available each day. There was an administrative support team available to the clinicians during consultations which included IT support. The prescribing doctors were paid on an hourly basis, per consultation and prescription.

The provider had a selection and recruitment process in place for staff. We reviewed two recruitment files (one clinical and one non-clinical). Although we saw appropriate checks undertaken for the non-clinical member of staff there were some gaps in the recruitment checks for the clinical member of staff. For example, there was no evidence of any interview process or conversation or of conduct in previous employment (such as references). There was no signed contract available for either staff.

The provider had undertaken Disclosure and Barring service (DBS) checks for all staff. (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 Managing Director advised that medical indemnity for clinical staff was covered through the corporate insurance which was specific to the type of service provided and covered clinical malpractice and we saw a copy of this.

The provider was able to show how it checked the professional registration for the clinicians employed via the General Medical Council (GMC) website. We saw that these were all up to date. However, there was no systematic process in place to flag when registration was due for renewal so that follow up checks could be completed to ensure it was still valid.

Newly recruited clinical staff received induction training which covered the use of the Healthsteer Limited clinical system and introduced them to the supporting team.

Inadequate

Are services safe?

The provider told us their clinical staff also currently worked in the NHS and that they were responsible for their own training. The provider had not specified training requirements of clinical or non-clinical staff and checks were not routinely undertaken to ensure all staff had completed and were up to date with relevant training such as in relation to safeguarding, Mental Capacity Act or information governance.

Prescribing safety

All medicines were prescribed to patients during a consultation, the service did not offer repeat prescriptions without a consultation taking place. If a medicine was deemed necessary following a consultation, the GPs could issue a private prescription to patients. The provider/leaders told us they used a formulary which their GPs would be expected to prescribe from. We were told that the formulary was under review at the time of the inspection and we were provided with an updated document following the inspection. We saw evidence that medicines were prescribed outside of these formularies in the clinical records we reviewed. The service did not prescribe some medicines liable to misuse.

Consultation notes documented advice given to patients about their medicines. We were told that where medicines were used off-label or outside of their license this would be discussed with the patient and documented in the consultation notes. We did not see this happening for one episode of off-label use. 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 service prescribed antibiotics when indicated, we were told that GPs were required to prescribe within national antimicrobial guidance. We saw consultations where antibiotics were not always prescribed with sufficient information for the patient to receive them safely or in line with national guidance.

We saw repeated prescriptions for opioid containing analgesics provided to patients, in one case the service recorded 28 weeks' worth of medicines being prescribed to one patient in just two months. This had not been identified by the service's quality assurances processes and the patient had not consented for their information to be shared with their GP. However, we saw another patient who had requested an opioid containing analgesic regularly for three months and given consent for their GP to be contacted and was refused a subsequent supply by the service following discussions with their GP.

There were protocols in place for identifying and verifying patients and General Medical Council guidance was followed.

We were advised that patients could choose a pharmacy where they would like their prescription dispensed. A copy of the prescription was sent electronically to the pharmacy of the patient's choice and the signed paper prescription was sent by recorded delivery to the pharmacy within 72 hours. The pharmacy was provided with access to an electronic system to verify the prescription, but patients were made aware the medicines may not be dispensed until the signed prescription had been received.

The service provided a prescription security policy that was out of date and not relevant to the processes followed by Healthsteer as it referred to receipt and storage of blank prescription paper. In addition, it did not mention security of the prescription details when they were sent to the dispensing pharmacy.

Information to deliver safe care and treatment

Inadequate

Are services safe?

On registering with the service, and at each consultation patient identity was verified. GPs had access to patient photographic identification which they could check at the start of the consultation.

We were told that the clinician was unable to go back into a consultation record once it had been saved. This had implications for clinicians to add any additional comments if needed to the record.

Management and learning from safety incidents and alerts

The provider had policies in place for serious incidents and for accidents and incident reporting, these were not practice specific and did not clearly set out the process for reporting, investigating and sharing learning from incidents internally. We were told there had been no serious incidents since the service had opened. The Customer Service lead maintained a log of any issues arising on a daily basis that required follow up, this would include any incidents, tasks or complaints that had occurred during the day. The Customer Service lead told us that they dealt with anything they could at the time and escalate anything they couldn't. Twice weekly administrative meetings were held to discuss any issues arising that needed to be discussed. However, we found the systems in place did not facilitate a process in which incidents were clearly identified, to review potential trends or patterns and for sharing any learning.

The service had a process for ensuring relevant Medicines and Healthcare products Regulatory Agency (MHRA) alerts were disseminated to their clinicians. We saw that the service had removed a medicine from their formulary based on published safety concerns. However, we did not see a process which provided assurance that clinicians were taking action based on those alerts. The service was not receiving or disseminating MHRA Drug Safety Updates, this was addressed during our inspection.

Inadequate

Are services effective?

We rated effective as Inadequate because we identified care and treatment that was not delivered in line with current evidence-based guidance. Within the scope of the service there was a lack of information sharing with patient GP where it was in the interests of patient safety to do so. Systems for quality improvement were not fully effective.

Assessment and treatment

We reviewed 28 clinical consultations and of those we identified concerns with the care and treatment with 16 of them. This did not demonstrate that there was adequate assessment of patients' needs and of care delivered in line with relevant and current evidence-based guidance and standards, including National Institute for Health and Care Excellence (NICE).

We were told that each online/ telephone consultation lasted for 10 minutes. If the GP had not reached a satisfactory conclusion there was a system in place where they could extend the call. Patients were advised after eight minutes that they could choose to extend the call for an additional fee if needed although the provider advised this would be waived if there were urgent medical concerns. We saw an example during our review of records where this had not happened, and the consultation had been terminated before follow-up could be arranged.

Patients completed an online form when they registered which included information about their past medical history, medicines and any allergies. There was a set template to complete for the consultation that included the reasons for the consultation and the outcome to be manually recorded. Once the consultation record had been completed and submitted it could not be viewed or updated by the clinician.

We reviewed 28 consultation records. Issues identified from our review of consultations included the unsafe clinical treatment of a child; four consultations in which there was unsafe care and treatment provided to patients with long-term conditions; four consultations where there had been unsafe prescribing of controlled drugs; three cases where prescribing did not follow national guidance and four cases where prescriptions had been issued without clinical indication or confirmation of a condition.

There had been no attempt to contact the patients GP to share information where it had been in the interests of patient safety to do so or to explore the reasons why the patient did not wish to share information with their GP. This included patients with depression, long term conditions and those prescribed controlled drugs. We saw records where patients had refused to share information with the GP and consultations had gone ahead where it was unsafe to do so.

The GPs providing the service were aware of the strengths (speed, convenience, choice of time) of the service but did not always adequately consider the limitations (inability to perform physical examination and tests) of working remotely from patients.

The provider told us that they had considered appropriate conditions they could treat which was displayed on the website. The customer services team told us that they would contact the clinician if they were unsure whether a patient should be seen, to check the clinician was happy to do so. If the clinician could not manage the patient's request, this was explained to the patient and a record kept of the decision. We saw on the practice website a condition listed that was not suitable for an online consultation.

The provider told us that they monitored consultations but provided no evidence of this. However, the provider shared with us prescribing audits they had undertaken. We were told that the results were shared with the individual clinicians to support learning and improvement, although we did not see evidence of this.

Inadequate

Are services effective?

Quality improvement

The provider told us that they were eager to continue to improve and develop the service. Quality was largely measured through patient feedback on the consultation. We also saw evidence of prescribing audits undertaken. This included:

Antibiotic prescribing audit undertaken in quarter one and two of 2021 which looked at 27 prescriptions against local primary care guidelines.

There was also a prescribing audit undertaken in quarter one and two of 2021 which looked at 40 prescriptions against the condition for which they were prescribed. We were concerned about the effectiveness of the audit in improving prescribing as on two occasions incorrect advice had been given in response to the audit findings.

The provider advised us that where issues were identified they were discussed with the individual prescribing GP for learning. Although, there was no mention of the audits in the doctors meeting for wider learning and sharing and we saw no other documented evidence of this.

Staff training

All staff completed induction training which consisted of an induction manual, which introduced the supporting Healthsteer team, how to use the Healthsteer software and open and close a consultation. The manual included a section on adult safeguarding concerns which was confusing in that the steps went on to include reporting a child safeguarding concern. There was also a link to GMC guidance on remote prescribing which stated the page no longer existed. The provider advised us that during the system training clinicians were shown how to report a safeguarding concern.

The provider had not identified any specific training requirements for their staff and no systems for monitoring staff training were in place. There was an assumption that clinical staff received relevant training in their NHS roles. When we asked for evidence of specific training the provider had to contact the individual clinicians and we were provided with a range of ad hoc training.

The provider advised that any updates or information the clinicians needed to be aware of was disseminated through a shared messaging application and emails. The provider had recently introduced a doctors clinical meeting for sharing information. There was also ongoing support available from the administrative team to clinical staff during the consultation period.

Evidence of clinical revalidation and appraisals were maintained by the team for clinical staff. This is the process by which a licensed doctor maintains their professional registration and can continue to practise in the UK.

We saw that administration staff received regular performance reviews where they could discuss any development needs.

Coordinating patient care and information sharing

Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, through the information patients provided. The provider did not undertake any routine tests and advised that they did not routinely see patients for the treatment of long term conditions for which monitoring was required. We were told that proof of previous prescribing was required in these instances, although we saw cases where this had not occurred and no clear rationale for the decision to prescribe.

Inadequate

Are services effective?

If patients called for an appointment the customer services lead advised that they would speak with the clinician first to ensure they were happy for the consultation to go ahead. We saw some examples of patients being signposted to more suitable sources of treatment for example, where a physical examination might be needed to ensure safe care and treatment.

All patients were asked for their GP details in order to use the service. Patients were then able to give or decline their consent for individual consultation information to be shared with their GP. We saw instances where it was unclear how it was determined safe to prescribe without information being shared with the patients GP. We also saw that even when consent had been given, information was not routinely shared with the patient's GP.

When making referrals to other services. The GP entered the referral information onto the clinical system. This was picked up by the administrative team and was sent where the patient wanted to attend. If the patient wished to go through the NHS route a referral letter was given to the patient to take to their GP. We were told there had been 18 referral letters produced in the last year.

There were no systems in place for monitoring the appropriateness of referrals to improve patient outcomes.

Supporting patients to live healthier lives

The provider's website contained a limited range of health and wellness information which were largely for promoting the service.

There was limited evidence of any health advice given within the patient records reviewed due to the nature of the service. We saw examples in records reviewed where patients had not been given signposting to other services to support them.

Good

Are services caring?

We rated caring as Good because, the provider actively sought and received positive feedback from patients who used the service. There was support for patients in using the service and queries were responded to in a timely manner.

Compassion, dignity and respect

We were told that the clinicians undertook video/telephone consultation remotely from their homes and that they would be asked to show the office they would be working from on employment as a one off. We saw that staff had signed confidentiality agreements and were told they received internal training on information governance.

We did not see or speak to any patients directly on the days of the inspection. However, the provider advised that they sought feedback from patients about the overall service and from patients in relation to their consultation. They told us that they shared feedback with the individual clinicians.

The provider shared patient feedback from 130 patients who had received appointments between April and July 2020. The overall rating received was 4.7 out of 5 stars. Where comments were given these were generally positive about the service and the professionalism of staff.

The provider also collected patient feedback through their provider portal. There were five comments, three were positive, one negative and one that was a query about the information collected prior to consultations.

We saw that the provider responded to information provided through feedback and had taken action to respond where possible. For example, software was adapted so that prescriptions could be sent to a pharmacy that can deliver prescriptions to patients.

Involvement in decisions about care and treatment

Information was available on the provider's website about how to use the service and costs involved. Patients could also obtain support through live chat and online messaging or through the main contact telephone number. There was a dedicated team to respond to any enquiries and technical support required.

Where technical issues occurred during consultations patients were given an alternative appointment and we saw evidence of this happening.

Patients did not have access to information about the clinicians/GPs working for the service ahead of the appointment. Consultations were held with the available clinician at the time. If patients had a particular request or need for example, a request to see a male or female GP or a GP who could speak a specific language then they could call the service to arrange. Where possible specific requests would be accommodated.

Patient surveys undertaken did not specifically ask for feedback on particular aspects of the patient's consultation for example satisfaction with explanations of their condition or treatments. Feedback was more general with opportunities to add further details on the service they received as free text.

Although the provider told us that they recorded video consultations there was currently no systems for providing a copy to the patient, which the provider advised was due to confidentiality concerns.

Requires Improvement

Are services responsive to people's needs?

We rated responsive as Requires improvement because we found patients with urgent needs did not always have their calls extended or followed up where appropriate; and information was not readily available to advise patients as to how they could raise a complaint.

Responding to and meeting patients' needs

Patients accessed the service through the provider's website, which was available 24/7. Patients were required to provide a reason for the consultation and complete an online form which requested information about their past medical history, current medicines and allergies. Online appointments were available Monday to Friday, between 8am and 8pm.

Healthsteer Limited was not an emergency service and patients were advised to contact 999 in an emergency, which was made clear on their website. There was also a list of conditions they treated on their website.

Once an appointment had been booked, the patient entered a virtual waiting room at the allotted time and would then be let into the consultation by the clinician / GP. The maximum length of time for a consultation was 10 minutes. After eight minutes patients received an alert to allow them to extend the consultation for an additional fee and after 10 minutes the consultation was automatically ended. We were told that if there were connection problems the patient was offered another appointment and we saw an example of this. We were also told that the clinician could extend a call if there were concerns about a patient, although we saw an example of this it did not always happen in practice.

The digital application allowed people to contact the service from abroad, but all medical practitioners were based within the United Kingdom. Any prescriptions issued were delivered within the UK to a pharmacy local to the patient's address or requested location. The customer services team told us they checked stock was available before sending the prescription.

Tackling inequity and promoting equality

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

There was no information about the individual GPs on the provider's website at the time of booking. Patients could request information about the GPs available if they contacted the customer services team. If patients wanted a male or female GP or a GP that spoke a specific language, they would need to contact the customer service team. Type talk was available alongside the video consultation if needed. The Healthsteer website could also be translated into multiple languages.

Managing complaints

Information about the provider's complaints policies and processes were not easily accessible. We asked the provider about their complaints policy and processes. The provider was not able to clearly advise us as to the information available to patients on how to make a complaint. It was suggested by the provider that this information was available on their website. We were unable to locate any information about raising a complaint on the provider's website and a link in the Healthsteer terms and reference to a complaints procedure led to a page that could not be found.

The provider told us that complaints tended to come through their feedback form and that they were dealt with quickly, usually within a couple of days. Complaints were recorded on a general spreadsheet with other incidents and tasks that

Requires Improvement

Are services responsive to people's needs?

needed to be addressed. The system for maintaining complaints did not make it easy to identify how many complaints there had been as it was incorporated into a more general log of incident and tasks. The system also did not make it easy to monitor complaints to ensure they were not missed and managed in a timely way and to identify any specific themes or trends and for sharing learning.

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. The provider's set of terms and conditions and details on how the patient could contact them with any enquiries was also available. Information about the cost of the consultation was known in advance and paid for before the consultation appointment commenced. The costs of any resulting prescription or medical certificate were handled by the administration team following the consultation.

The provider had not identified any specific training requirements for their staff. Training records seen indicated that some clinical staff had received training about the Mental Capacity Act 2005 through other employment.

We were advised that children were not able to access the service without an adult.

Consent was routinely requested for sharing information relating to the online consultation with the patients usual GP. However, we saw several examples during our review of clinical records where it would have been appropriate to share the information in the interest of patient safety but had not happened.

Inadequate

Are services well-led?

We rated well-led as Inadequate because the provider did not have effective systems in which to monitor the quality and performance of the service to support improvement or for managing risks.

Business Strategy and Governance arrangements

The provider told us that they aimed to provide high quality responsive services to people who may struggle to obtain appointments with a GP.

There was an organisational structure and staff were aware of their own roles and responsibilities and how they fitted into the organisation. There was a range of policies, but these were not made service specific or clearly documented local processes and procedures. Furthermore, staff were not easily able to locate the policies on our request. Policies stated that they were to be reviewed on a 12 month basis but this was not consistently the case from those we reviewed.

The provider did not have a comprehensive understanding of the performance of the service. The clinical system in place did not allow easy access to patients full clinical records for review and monitoring purposes. This relied on requests to the provider's IT support team to retrieve the information from the system database. During the inspection the provider struggled to provide us with information from the clinical records to review in a timely way.

The provider had recently introduced performance monitoring processes on a quarterly basis focused on prescribing audits. The audits did not specifically comment on the overall quality of consultation and the associated recording of the consultation. The audits were not carried out by a clinician trained in general practice and undifferentiated care and we identified a couple of areas where conclusions made from individual situations had been inaccurate. We were advised that results from the prescribing audits were fedback directly with the individual GPs. We did not see any general discussion about the overall audit findings at the clinical meetings, however these meetings had only recently been introduced.

The provider did not have effective arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. Although we were told by the management team about various systems and processes, these were not always embedded or carried through in the documentation we saw. There was also a lack of procedural guidance for staff to follow. For example, continuation of consultations where there were concerns about a patient, limitations on seeing patients with long term conditions, safety concerns in relation to repeat consultations and prescribing and sharing information as appropriate with a patients usual GP. There was a lack of clear requirements for training and monitoring of this and no systems for providing assurance of the competence of clinical staff who were not trained as GP or providing undifferentiated care.

Care and treatment records were legible and securely kept. However, they did not always demonstrate a full assessment of the patients risks had been considered.

There was a general lack of effective systems to support learning and improvement for example, from incidents, complaints, audits and safety alerts.

Leadership, values and culture

Inadequate

Are services well-led?

Healthsteer Limited leadership consisted of a non clinical managing director (who was also the registered manager) and five clinical directors (all were secondary care consultants who were also known as the 'founding doctors'). The clinical directors also had roles outside of Healthsteer Limited. One of the clinical directors we spoke with told us that they had clinical governance lead role at Healthsteer and worked for the service 8 to 12 hours per week. We were told that the Clinical Directors were contactable if needed. There was no GP on the leadership team.

There were five locum doctors (four GPs and a secondary care doctor) who worked remotely. The doctors were given an online training manual on induction which included the mission and vision of the service; which was 'To provide easy and convenient access to clinicians. One patient, one Doctor and one amazing customer experience at a time'.

The locum doctors were mainly supported by the non-clinical team on a day to day basis. There was limited engagement with other clinical staff and information was usually through a mobile phone messaging application or emails. The provider had recently introduced clinical meetings but only one set of minutes were available and there were no clear set agenda items for discussion.

Staff we spoke with told us that there was an open and transparent culture and that if a patient was unhappy they would try and resolve the issue with them as quickly as possible and apologise. The provider advised us that there had not been any incidents in which duty of candour had applied.

Safety and Security of Patient Information

Systems were in place to ensure that all patient information was stored and kept confidential. The provider explained that they asked GPs working remotely to risk assess the environment they worked in. The clinical system used was an in-house purpose built cloud based clinical system. We were told staff accessed the clinical system via a password. Information stored was encrypted and could not be re-accessed once saved. This meant staff could not update records at a later date if they had missed something from the records or review their notes after being completed. The provider was able to identify who had made the record. Staff were supported by an IT team if they needed to access records for audit or monitoring purposes. There provider was registered with the Information Commissioner's Office. The provider told us that the Business Continuity Plan contained details as to what they would do with patient information if they ceased trading. However, we saw no mention of this in the plan. Furthermore, the plan contained no details as to how they would manage business continuity in the event of an interruption to services.

Seeking and acting on feedback from patients and staff

The provider had several ways in which patients could provide feedback on the service. This included online reviews, the online patient portal and during the patient consultation where patients could rate the GP consultation. We saw that online comments had been responded to. The provider told us that they feedback to individual GPs and investigated where consultations were rated low to understand why. Where patients had provided feedback via the portal, we saw that suggestions had been considered to see if they could be implemented.

There was evidence that the GPs could provide feedback about the quality of the operating system and any suggestions were logged, discussed and decisions made for any improvements to be implemented. There was administrative and IT support available to the clinicians when on duty. The clinicians could report any issues to this team who could raise the issues at their bi-weekly meetings with the managing director. There was also opportunities for clinical staff to provide feedback at the monthly clinical meetings and directly with the registered manager.

Inadequate

Are services well-led?

The provider had a whistleblowing policy in place. (A whistle blower is someone who can raise concerns about practice or staff within the organisation.) However, this was not service specific and contained no designated leads for the dealing with issues raised under whistleblowing.

Continuous Improvement

The leadership team were proud of the service they provided in giving patients access to a doctor wherever they were and when they needed one. The customer services team was always available to support the clinical staff and patients during opening hours and deal with any issues arising as quickly as possible.

There were regular meetings with the non-clinical team to discuss issues relating to software and customer services issues.

The provider had recently introduced prescribing audits however these needed to be strengthened in order to demonstrate an effective system for service improvement. Clinical meetings had also been introduced as a way of sharing key information and learning. However, the provider was unable to demonstrate that there was an effective system for identifying and sharing learning. For example, in relation to incidents, complaints, audits and safety alerts.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** **The provider had failed to establish effective systems to assess, monitor and improve the quality and safety of the services being provided and to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.** **In particular we found:** • The provider could not provide timely and appropriate organisational documents relating to the delivery of the service. • The provider could not provide timely access to clinical information for the assessment of the quality of services provided. • The provider was unable to demonstrate effective quality improvement activity. For example, through quality monitoring and audits. • The provider was unable to demonstrate effective systems for learning and improvement. For example, from incidents, complaints and audits. • The provider was unable to demonstrate effective systems for managing patient safety alerts and updates. Including those relating to medicines. • Policies and procedures were not service specific or effective in supporting staff in the safe delivery of the service. • The provider did not have systems for providing assurance that doctors working in the capacity of GPs were competent in delivering undifferentiated care.

This section is primarily information for the provider

Enforcement actions

- The provider had not identified training requirements for staff or had systems in place for monitoring staff training was up to date.
- Patient information in raising a complaint was not made readily available.

The enforcement action we took: We have issued a Warning Notice to the provider requiring they become compliant by the 30 September 2021.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. How the regulation was not being met: The provider had failed to ensure assessments of the risks to the health and safety of service users of receiving care or treatment were being carried out. In particular: • In the care and treatment of children. • In the care of patients with long-term conditions. • In the sharing of information with a patients usual GP where it was in the interests of patient safety to do so. The provider had failed to ensure the proper and safe management of medicines. • In the prescribing of controlled drugs. • In the absence of clear clinical indication for prescribing. • In the prescribing of off-licence medicines. • In line with national prescribing guidelines. **The enforcement action we took: We have issued a Warning Notice to the provider requiring they become compliant by the 30 September 2021.**