

The GP Service (UK) Limited

Quality Report

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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.

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The GP Service (UK) Ltd.

The GP Service (UK) Ltd provides an online GP consultation service. They employ GPs on the General Medical Council (GMC) GP register to work remotely in

undertaking patient consultations. Patients are able to book a consultation with a GP Monday to Sunday 8am until 8pm. Consultations were via a video call or assessment questionnaire. Medicines prescribed were collected by the patient, or delivered, by an affiliated pharmacy (which we do not regulate). No medicines were delivered by post to patients.

Summary of findings

We found this service did not provide safe and well-led services but did provide effective, caring, and responsive services in accordance with the relevant regulations.

Our key findings were:

- The provider had clear systems to keep people safe and safeguarded from abuse.
- There was a comprehensive system in place to check the patient's identity.
- There were systems in place to mitigate safety risks including analysing and learning from significant events and safeguarding.
- There were appropriate recruitment checks in place for all staff.
- Prescribing was monitored to prevent any misuse of the service by patients and to ensure GPs were prescribing appropriately. However there was no system in place for auditing incidents, near misses and clinical errors picked up at the affiliated pharmacies, at the point of dispensing, by the pharmacist and, therefore, no opportunity to review them.
- There were systems to ensure staff had the information they needed to deliver safe care and treatment to patients.
- The provider was aware of and complied with the requirements of the Duty of Candour.
- Patients were treated in line with best practice guidance and appropriate medical records were maintained. However the provider did not ensure patients diagnosed with a long term condition had received recommended monitoring of their condition; in line with national guidance.
- The provider's website did not give information about the GPs who worked for them so patients were unable to book a consultation with a GP of their choice or see details of their professional registrations.
- The provider had a programme of ongoing quality improvement activity.
- An induction programme was in place for all staff and GPs registered with the service received specific induction training prior to treating patients. Staff, including GPs, also had access to all policies.
- The provider shared information about treatment with the patient's own GP in line with General Medical Council guidance. However there was no policy in place and no evidence that risk assessments had been undertaken should a patient refuse permission for information to be shared.
- Staff we spoke with were aware of the organisational ethos and philosophy and told us they felt well supported and that they could raise any concerns.
- There were clinical governance systems and processes in place to ensure the quality of service provision. However these did not always operate effectively, for example in relation to management oversight of adherence to policies.
- The provider encouraged and acted on feedback from both patients and staff.
- Systems were in place to protect personal information about patients. Both the company and individual GPs were registered with the Information Commissioner's Office.

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

- Ensure systems and processes are reviewed in order that that good governance and management oversight of operational delivery is consistently achieved.
- Ensure risk assessments and processes are in place that follow good practice guidelines and ensure safe care and treatment.

The areas where the provider should make improvements are:

- Ensure patients have access to information about GPs they are able to consult with.
- Ensure risk assessments are undertaken should a patient refuse permission for information to be shared with their own GP.

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

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

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

- Patient identity was checked on registration and at every consultation. However the providers policies were not always adhered to when prescriptions were dispensed, which the provider unaware of until raised at the inspection
- Medicines were being prescribed for long term conditions. However there was no provision within the service for the GP to undertake monitoring of these conditions, and no evidence that they ascertained that it was being carried out elsewhere.
- There was no clear information on the consultation form to explain when medicines were being used outside of their license. There was also no confirmation that the patient had consented and acknowledged that they understood this information.
- There was no oversight by the provider of The Medicines and Healthcare products Regulatory Agency (MHRA) safety alerts being received and actioned and no person responsible for these alerts if the CEO was away from the business. We received information post inspection that the provider had changed their processes to rectify this.
- There was no system in place for auditing incidents, near misses and clinical errors picked up at the affiliated pharmacies, at the point of dispensing, by the pharmacist.
- There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. The provider was aware of and complied with the requirements of the Duty of Candour and encouraged a culture of openness and honesty.
- All staff had received safeguarding training appropriate for their role. All staff had access to local authority information if safeguarding referrals were necessary.
- There were enough GPs to meet the demand of the service and appropriate recruitment checks for all staff were in place.
- In the event of a medical emergency occurring during a consultation, systems were in place to ensure emergency services were directed to the patient. The provider had a business contingency plan.
- Prescribing was monitored and consultations were monitored for any risks.

Summary of findings

- There were systems in place to meet health and safety legislation and to respond to patient risk.

Are services effective?

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

- Each GP assessed patients' needs and delivered care in line with relevant and current evidence based guidance and standards, for example, National Institute for Health and Care Excellence (NICE) evidence based practice. We reviewed a sample of consultation records that demonstrated appropriate record keeping and patient treatment.
- The service had a programme of ongoing quality improvement activity. For example, we saw one audit of five consultations where areas for improvement had been identified and feedback given to the individual clinician in order to improve patient outcomes.
- There were induction, training, monitoring and appraisal arrangements in place to ensure staff had the skills, knowledge and competence to deliver effective care and treatment.
- The service had arrangements in place to coordinate care and share information appropriately for example, when patients were referred to other services. In medical records we looked at we saw that patients who had consented to the sharing of information with their GP. However we did not see that there was a policy in place or that risk assessments had been undertaken should a patient refuse permission for information to be shared; to ensure that prescribing was in line with the GMC remote prescribing guidelines.
- During video consultations we were told patients were given health advice as appropriate, however we saw no written evidence of this. The provider told us that the provision of health promotion advice on their website was an area they were currently developing.

Are services caring?

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

- We were told that GPs undertook consultations in a private room, for example in their own home. The provider had a policy in place which GPs relating to professional standards sanctions in place should this not be adhered to.
- We did not speak to patients directly on the days of the inspection however; we did review data from patient feedback

Summary of findings

surveys. An independent survey conducted via Trust Pilot showed that four positive reviews had been posted since the service launched four months ago. Following consultations, patients were emailed to ask whether treatment had been effective or whether symptoms were still present and to ask for feedback on the service they had received.

Are services responsive to people's needs?

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

- Patient information guides about how to use the service. There was a dedicated team to respond to any enquiries and technical issues.
- The provider's website did not give information about the GPs who worked for them so patients were unable to book a consultation with a GP of their choice or see details of their professional registrations.
- Patients could access the service online from their own home or from a private room within an affiliated pharmacy. A patient who chose to consult via online assessment questionnaire could collect any medicines prescribed, from one of the affiliated pharmacies.
- There was a complaints policy which provided staff with information about handling formal and informal complaints from patients and information was made available to patients about how to make a complaint. No complaints had been received since the launch of the service in February 2017.
- Consent to care and treatment was sought in line with the providers policy. All of the GPs had received training about the Mental Capacity Act.

Are services well-led?

We found that this service was not providing well-led care in accordance with the relevant regulations.

- There were business plans and a governance framework to support clinical governance and risk management however these did not always operate effectively. Policies were not always adhered to and there was lack of managerial oversight.
- There was a management structure in place and the staff we spoke with understood their responsibilities. Staff were aware of the organisational ethos and philosophy and they told us they felt well supported and could raise any concerns with the provider or the manager.

Summary of findings

- The service encouraged patient feedback. To enhance the patient experience the service were developing an online patient participation group. There was evidence that staff could also feedback about the quality of the operating system and any change requests were discussed.
- Systems were in place to ensure that all patient information was stored securely and kept confidential. There were systems in place to protect all patient information and ensure records were stored securely. Both the service and the GPs were registered with the Information Commissioner's Office.
- The service was launched five months ago and development work was ongoing including, patient information regarding health promotion and the continuing reviewing of all the assessment questionnaires to ensure they were in line with best practice.

The GP Service (UK) Limited

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector accompanied by a GP specialist advisor and a CQC pharmacist specialist. A Deputy Chief Inspector observed the inspection.

Background to The GP Service (UK) Limited

The GP Service (UK) Ltd launched its online service in February 2017 and is based in central London. At the time of the inspection 163 patients were registered with The GP Service (UK) Ltd. Patients are able to consult with a qualified GMC registered GP via online assessment questionnaires or through secure video calling. The operating model of the service enables any medicines prescribed following consultations, to be available for collection through independent pharmacies that The GP Service (UK) Ltd has signed up as affiliated pharmacies. Patients then choose to collect their treatment from one of these affiliated pharmacies or to have medicines delivered to them by that pharmacy. The service also allows doctors, to provide prescriptions where appropriate, as well as referral letters and fit notes. If there is no affiliated pharmacy close to the patient, prescriptions can be posted to the patient. If patients choose to consult via an online assessment questionnaire, any medicines prescribed must be collected from an affiliated pharmacy, selected by the patient.

We inspected the online service The GP Service (UK) Ltd at the following address from where the provider is registered to provide services:

Lloyds Chambers 5th Floor, 1 Portsoken Street, London E1 8BT.

The service is led by a chairman and a chief executive officer and supported by a leadership team of five which included medical, technological and sales expertise. There were GPs who carried out the online consultations remotely; usually at their home, one of whom was based outside the UK.

A registered manager is in place. 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.

Why we carried out this inspection

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.

How we carried out this inspection

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:

Detailed findings

- Spoke with a range of staff including the chairman, the medical director (a GP who undertook consultations), the medical advisor, the registered manager and members of the IT team employed by the service. The GP specialist advisor spoke with the second GP who undertook consultations post inspection. We also spoke with three pharmacists who worked in affiliated pharmacies.
- Reviewed organisational documents.
- Reviewed the organisation's website.
- Reviewed medical 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.

Are services safe?

Our findings

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

Keeping people safe and safeguarded from abuse

All staff who worked for the service and who would have contact with patients had received training in safeguarding and whistleblowing. They 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. However there was evidence that not all staff were aware of these policies.

The service did not treat children and the provider ensured children were unable to access the service by undertaking video consultations, which also required photographic identification. Any patients who were consulted using assessment questionnaires were required to collect any medicines prescribed in person from an affiliated pharmacy.

Monitoring health & safety and responding to risks

Incidents were logged by whoever raised them. We saw that those raised were reflected on and actions that could be taken to prevent reoccurrence detailed. All incidents were reviewed by the CEO. We saw that incidents were a standing agenda item at the monthly medical advisory committee (MAC) meetings.

All clinical consultations were rated by the GPs for risk. For example, when assessing a consultation questionnaire, if the GP thought there may be serious mental or physical health issues that required further attention, the GP would arrange a telephone or video call with the patient to have further discussions. We were told that as the service was in its infancy, in order to be able to monitor risk effectively, all patients who completed an assessment questionnaire would receive a telephone call to have a discussion with a GP. However, we were informed by a GP that currently only approximately half of these patients were contacted by the GP.

The provider headquarters is located within modern purpose built offices, housing the IT system, management and administration staff. Patients are not treated on the

premises and GPs carry out the online consultations remotely usually from their home. Administration staff had received training in health and safety including fire safety. We saw that all appropriate insurances were in place, for example public and employee liability.

The provider expected that all GPs would conduct consultations in private and maintain the patient's confidentiality. Each GP used their laptop to log into the operating system, which was a secure programme.

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

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, which included access to the IT team.

The provider had a selection process in place for the recruitment of all staff. Required recruitment checks were carried out for all staff prior to commencing employment. Potential GP candidates had to be registered with the General Medical Council (GMC), on the National Performers' List and up to date with their appraisal. Those GP candidates that met the requirements of the provider then had to provide documents; including their professional indemnity cover as well as insurance; proof of registration with the GMC; proof of their qualifications and certificates for training in safeguarding and the Mental Capacity Act. The provider had also purchased additional medical indemnity insurance.

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. The provider kept records for all staff including the GPs. There was a system in place that flagged up when any documentation was due for renewal such as their professional registration.

Prescribing safety

All medicines prescribed to patients from online forms or video consultations were monitored by the provider to ensure prescribing was evidence based. If a medicine was

Are services safe?

deemed necessary following a consultation, the GPs were able to issue private prescriptions to patients. The GPs could only prescribe from a set list of medicines which the provider had risk-assessed; such as sildenafil for erectile dysfunction, medicines for emergency hormonal contraception and finasteride for hair loss treatment. There were no controlled drugs on this list. Once the GP prescribed the medicine and correct dosage of choice, relevant instructions were given to the patient regarding 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.

We asked the provider what systems were in place to identify and analyse any incidents, near misses and clinical errors picked up by the point of dispensing by the pharmacist. We were told that any issues that arose between the GPs and the supplying pharmacy were dealt with as they arose. There was no system in place for auditing these types of incidents, and therefore no opportunity to review them.

We were told by the GPs, and patient consultation records confirmed, that medicines were prescribed for people with long term conditions such as asthma and diabetes; both conditions which require regular monitoring. There was no provision within the service for the doctor to undertake this monitoring, and no evidence that they ascertained that it was being carried out elsewhere.

The service encouraged good antimicrobial stewardship by only prescribing from a limited list of antibiotics which was based on national guidance.

The service prescribed some medicines outside of their licensed use, for example for the treatment and prevention of altitude sickness. (Medicines are given licences after trials have shown that they are safe and effective for treating a particular condition. Use for a different medical condition is called unlicensed use and is a higher risk because less information is available about the benefits and potential risks). We did not see that there was clear information on the consultation form to explain that the medicines were being used outside of their licence, or that patients had received information and acknowledged they understood it. We were told that this was discussed with patients during a consultation. However we did not see

written evidence of this in a medical record that we looked at. There was no evidence that additional written information to guide the patient when and how to use these medicines safely was supplied with the medicine.

Prescriptions were monitored in particular for any form of abuse, for example, excessive requests. During consultations, previous prescribing history and medical history were visible to the GP on the patient's medical record with the service.

Information to deliver safe care and treatment

On registering with the service, and at each consultation patient identity was verified and the GPs had access to the patient's previous records held by the service.

There were protocols in place for identifying and verifying the patient and General Medical Council guidance, was followed. On registration with the service, patients were required to enter their details which were checked to ensure multiple accounts were not being opened by the same person. Patients were required to produce evidence of photographic identification at each video consultation. When medicines were collected from or delivered by a pharmacy, the service had sought to further mitigate risk by detailing in their policies that photographic ID would be checked. This meant that patients who had consulted via assessment questionnaires would also always have their identification check photographically. However we found that these processes were not always effective. We spoke with two pharmacists that worked in pharmacies registered to dispense prescriptions issued by the provider. Both told us that they undertook their usual ID checking at the point of dispensing a prescription but these did not usually include photographic ID checking. The provider was unaware of this when this was raised with them on the day of the inspection, which demonstrated a lack of management oversight of adherence to their policies. Post inspection we received information to demonstrate that steps had been undertaken to resolve this. All affiliated pharmacies had received an email to explain the importance of carrying out the photographic ID check. Business development managers who visit the pharmacies regularly were informed at the team meeting that this point must form part of their regular visits and training updates. The messaging on the screen during the stages of dispensing the prescriptions originally stated 'Photo ID' in the first stage and only 'ID' in the second stage, this had been updated to state 'Photo-ID' as a requirement at both

Are services safe?

stages. The text in which these messages are presented to the pharmacy had also been updated with better wording to explain the importance of this process. These are now displayed in a bright red colour to demand more attention.

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 two 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, a patient had consulted for a condition that required a physical examination to confirm diagnosis and the severity of the condition and was not pleased when told that a prescription could not be issued. The provider discussed how this could be managed more effectively and it was agreed that the messaging to patients would be improved on the website to make it clearer what could and could not be managed via video consultation.

We saw evidence from one incident 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.

There were systems in place to deal with medicine and patient safety alerts. Medical alerts were assessed by the chief executive officer (CEO) who was also a registered pharmacist. All relevant clinical alerts were forwarded to all GPs for information. Any actions taken, which resulted in changes, were cascaded to staff, including clinicians. Action was taken to change consultations if necessary. Any patients that may be affected, as a result of a safety alert, were identified and they were contacted as appropriate. We were shown an example of the action taken in response to a patient safety alert. We also saw however that alerts were not received directly into the service. The CEO received alerts in relation to his role as a community pharmacist and a GP received alerts in relation to another post he held within the NHS. This meant that there was no oversight by the provider of alerts being received and actioned and no person responsible for these alerts if the CEO were away from the business. Post inspection we received information from the provider that all senior staff for The GP Service UK Ltd had been signed up to the Medicines and Healthcare products Regulatory Agency (MHRA) email alert service and had been trained on actions to be taken in the event of receiving one of these.

Are services effective?

(for example, treatment is effective)

Our findings

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

Assessment and treatment

We reviewed 17 examples of medical records that demonstrated that each GP assessed patients' needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) evidence based practice.

We were told that each online consultation lasted for approximately 10 minutes. If the GP had not reached a satisfactory conclusion there was a system in place where the consultation could be extended or they could contact the patient again. We saw that over 90% of video consultations were booked via an affiliated pharmacy, where a patient had attended the pharmacy for advice and requested referral for a consultation with a GP. The patients were able to consult with the GP from The GP Service (UK) Ltd in a private room within the pharmacy.

Patients could also complete an online assessment questionnaire which included their past medical history. There was a set template to complete for the consultation that included the reasons for the consultation and the outcome to be manually recorded, along with any notes about past medical history and diagnosis. We reviewed medical records which demonstrated complete records and adequate notes were recorded. The GPs had access to all previous notes. At the end of the online assessment questionnaire a consultation and assessment was undertaken by a GP to determine the suitability of treatment requested.

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.. If a patient needed further examination they were directed to an appropriate agency. For example, we saw that a patient had been referred to an accident and emergency department for further investigation. If the provider could not deal with the patient's request, this was explained to the patient and a record kept of the decision.

At the time of the inspection the service had only been undertaking consultations for three months This meant

that there were limited data to support a meaningful evaluation of consultations and prescribing. One prescribing audit had been undertaken and we saw that there were plans in place to undertake monitoring of consultations and prescribing on a structured basis.

Quality improvement

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

- The service used information about patients' outcomes to make improvements. We saw a policy that stated that audits of clinical records would be carried out quarterly and that 10% of clinical records would be audited annually. We saw one audit of five consultations where areas for improvement had been identified and feedback given to the individual clinician in order to improve patient outcomes
- The service took part in quality improvement activity. For example, during an audit of patient notes it had been identified that a patient who had consulted for a urine infection had been given treatment. The patient's medical history would have indicated that further investigation should have been undertaken but this had not been advised. Actions to minimise the chances of this happening again included guidelines update and a quick reference guide available for GPs, on the IT system, and improved patient information on the website. Policies were amended to ensure prescribing was in line with remote prescribing guidelines. We were informed that a re-audit was planned to be undertaken in three months' time, to ensure updated policies were being adhered to.

Staff training

All staff had to complete induction training which consisted of, health and safety, policies and procedures, training, appraisal and professional development. Staff also had to complete other training on a regular basis for example on fire safety, information governance and safeguarding. The service manager had a training matrix which identified when training was due.

The GPs registered with the service had to receive specific induction training prior to treating patients. An induction log was held in each staff file and signed off when completed. Supporting material was available, for example, a GPs handbook, how the IT system worked and aims of the consultation process. There was also a regular bulletin

Are services effective?

(for example, treatment is effective)

sent out to all staff. The GPs told us they received excellent support if there were any technical issues or clinical queries and could access policies. When updates were made to the IT systems, the GPs received further online training.

Administration staff received regular performance reviews. All the GPs had to have received their own appraisals before being considered eligible at recruitment stage. Monitoring of performance of GPs was conducted by the provider as well as the GPs own professional annual appraisal and we saw evidence of this in the staff personnel files

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. We were informed that if patients consented, a letter was sent to their registered GP in line with GMC guidance. In the medical records we reviewed we saw that

consent had been received to share information with the patient's own GP. However we did not see that there was a policy in place or that risk assessments had been undertaken should a patient refuse permission for information to be shared, to ensure that prescribing was in line with the GMC remote prescribing guidelines.

Supporting patients to live healthier lives

When patients completed assessment questionnaires supplementary information was given to patients which supported healthier lives. The provider told us that they wished to develop the health promotion advice they delivered to patients on their website and that this was an area in development at present.

During video consultations we were told patients were given health advice as appropriate, however we saw no written evidence of this.

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, we did review data from patient feedback surveys. An independent survey conducted via Trust Pilot showed that four reviews had been posted since the service launched four months ago. Three patients rated the service as “excellent” and one as “great”.

Following consultations patients were emailed to ask whether treatment had been effective and to give advice if symptoms were still present and to ask for feedback on the service they had received.

Involvement in decisions about care and treatment

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

The provider’s website did not give information about the GPs who worked for them, to enable patients to book a consultation with a GP of their choice.

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

The service could be accessed through the website www.thegpservice.co.uk. Patients were able to consult with a qualified general medical council (GMC) registered doctor via online assessment questionnaires or through secure video consultation. The operating model of the service enabled any medicines prescribed following consultations, to be available for collection through independent pharmacies that The GP Service (UK) Ltd had signed up as affiliated pharmacies. The service was affiliated to pharmacies nationwide where prescriptions could be dispensed from. Patients could access the service online from their own home or within the pharmacy. A patient attending the pharmacy for advice who was found to require referral to a GP was able to access the website, book a consultation and undertake the consultation in a private room within the pharmacy. GPs were available for consultations between 8am to 8pm Monday to Sunday. A patient who chose to consult via online assessment could collect any medicines prescribed, from one of the affiliated pharmacies. Approximately 90% of patients had accessed the service from within an affiliated pharmacy.

The website allowed people to contact the service from abroad. Any prescriptions issued were delivered within the UK to one of the affiliated pharmacies of the patient's choice. If there were no affiliated pharmacies close to the patient a prescription could be posted to the patient for them to take to an alternative pharmacy. The provider further mitigated risks associated with this by putting in place comprehensive processes, which prevented misuse of the prescriptions. Each posted prescription contained a unique identifier code, which was used to ensure the prescription had not been previously dispensed, using a web based tool The GP Service (UK) Ltd had developed. The pharmacist then confirmed that photographic ID had been checked and this information was stored on the providers database.

The provider made it clear to patients what the limitations of the service were. This service was not an emergency service. Patients who had a medical emergency were advised to ask for immediate medical help via 999 or if appropriate to contact their own GP.

Patients requested an online consultation with a GP and were contacted at the allotted time. The maximum length of time for a consultation was 10 minutes. However, the provider offered appointments slots every 20 minutes which allowed for extended consultations should this be needed.

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 other than children under the age of 18.

Managing complaints

Information about how to make a complaint was available on the service's website. 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. At the time of the inspection the service had received no complaints.

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 video consultation was known in advance. A pre-authorisation of the patient's credit card was taken at the start of the consultation, in order that any resulting prescription or medical certificate costs could be included following consent from the patient. The costs of an online assessment questionnaire consultation was variable as this included the price of any medicines prescribed and was charged to the patient upon completion of the consultation.

Staff understood and sought patients' consent to care and treatment in line with legislation and taking into account guidance.

All GPs had received training about the Mental Capacity Act 2005. 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 not providing well-led services in accordance with the relevant regulations.

Business Strategy and Governance arrangements

The provider told us they had a clear vision to work together to provide a high quality responsive service that put caring and patient safety at its heart. We reviewed business plans that covered the next five years.

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. We saw that these had been written prior to the service being launched and had been reviewed four months post launch. We were told that they would be reviewed annually and updated when necessary.

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

There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions but these did not always operate effectively. For example, on the day of the inspection we found:

- Policies were not always adhered to, which the provider was unaware of until raised with them during the inspection, for example, the checking of photo ID at the affiliated pharmacies when they dispensed the medicines.
- There was a lack of oversight in some areas of the business, for example, identifying incidents near misses and clinical errors and Medicines and Healthcare products Regulatory Agency (MHRA) safety alerts
- There was no policy in place and risk assessments had not been undertaken should a patient refuse permission for information to be shared with their own GP or monitoring of long term conditions, to ensure that prescribing was in line with the GMC remote prescribing guidelines.
- All patients who completed an assessment questionnaire were to receive a telephone call to have a discussion with a GP. However, currently only approximately half of these patients were contacted by the GP.

The management team responded to these concerns and we received evidence post inspection that demonstrated that changes to processes were being made.

Leadership, values and culture

The service is led by a chairman and a chief executive officer and supported by a leadership team of five which included medical, technological and sales expertise. There were two GPs who carried out the online consultations remotely; usually at their home, one of whom was based outside the UK. A medical advisor was working with the service to develop services and ensure care to patients was in line with evidence based medicine. The board of the service comprised the chairman the CEO and the provider's financial backers that met regularly, but with no input from the medical team. A weekly Medical Advisory Committee meeting was held monthly and attended by the CEO, a GP and the medical advisor. Meetings for IT staff were also held monthly. We did not see evidence that outcomes from these individual meetings were shared with the other staff groups.

As part of its development and expansion of the service, the provider was looking to recruit additional GPs.

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. The service used its own web platform to conduct video consultations. 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. Both the service and the GPs were registered with the Information Commissioner's Office. 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 were emailed seven days after each consultation to ask for feedback. Patients could also post feedback online via Trust Pilot. To date four patients had posted

Are services well-led?

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

comments via Trust Pilot all of which were positive. The provider had also recently signed up to a service called 'iwantgreatcare.com' which offered patients the opportunity to leave reviews about the individual doctors.

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 whistleblower 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 provider consistently sought ways to improve. All staff were involved in discussions about how to run and develop the service, and were encouraged to identify opportunities to improve the service delivered. We saw from minutes of staff meetings where previous interactions and consultations were discussed.

Staff told us that the team meetings were the place where they could raise concerns and discuss areas of improvement. However, as the management team and IT teams worked together at the headquarters there was on-going 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.

We saw that the medical advisor was reviewing all the online assessment questionnaires to ensure they were in line with best practice. We also saw that the provider was working towards providing patients with health promotion advice in all treatment areas on their website in order that patients were able and empowered to manage their own condition where possible.

To enhance the patient experience the provider was developing an online patient participation group.

The provider was developing plans to work with an external translation service who provided translators with a clinical knowledge. A three-way consultation would be delivered with a GP Service (UK) Ltd GP, a translator in the language required and the patient

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Care and treatment must be provided in a safe way for service users.</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">• The provider had failed to evidence that informed consent had been obtained from patients receiving medicines outside of their licensed use.• The provider had failed to ensure patients who had been diagnosed with a long term condition and for whom they were prescribing medicines had received appropriate monitoring.
Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>Providers must operate effective systems and processes to make sure they assess and monitor their service.</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">• The provider had failed to ensure management oversight of systems and processes in relation to ID checks, risk assessments and adherence to policies.