Bluezone Health Ltd

Online services

Inspection report

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Bluezone Health Ltd on 5 December 2018 as part of our inspection programme.

Bluezone Health Ltd operates via an online app, which allows patients to contact a doctor (a consultant in emergency medicine) for an online consultation via a text "chat", video call or voice call. Where the consulting doctor considers it necessary for the patient to be seen in person, they can arrange for the patient to be seen by a Bluezone doctor at HCA Chiswick Outpatient & Diagnostic Centre (HCA), where staff have access to HCA's diagnostic and treatment facilities. During face to face consultations at HCA, doctors worked under practicing privileges granted by HCA, and therefore, this aspect of the service did not form part of the inspection.

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

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

- Arrangements were in place to safeguard people, including arrangements to check patient identity.
- Overall, prescribing was in line with national guidance; any unusual prescribing was identified and discussed in clinical team meetings. The service had not prescribed any medicines for use outside of their licence but we were told that should they do so, the patient would have any risks associated with this fully explained to them.
- Suitable numbers of staff were employed and appropriately recruited.
- Risks were assessed and action taken to mitigate any risks identified.

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

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

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

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

Summary of findings

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

- Overall, information about how to access the service was clear; however, from the information on their website it was not immediately apparent that face to face consultations were only available from a single site.
- The provider did not discriminate against any client group.
- Information about how to complain was available and processes were in place to handle and learn from complaints.

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

- The service had clear leadership and governance structures.
- A range of information was used to monitor and improve the quality and performance of the service.
- Patient information was held securely; however, the provider did not have arrangements in place to ensure that patient records would be stored in line with guidelines should they cease to trade.

The areas where the provider should make improvements are:

- Put in place arrangements in order to store patient records in line with guidance should the service cease to trade.
- Consider routinely enquiring and recording the location of the patient at the beginning of consultations.
- Put in place processes to ensure that arrangements in respect of the use of personal computers are adhered to by all staff.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Online services

Detailed findings

Background to this inspection

Background

Bluezone Health Ltd registered with CQC in April 2018; initially the service was piloted by a small number of patients, and was made available to the public in November 2018.

The service operates via an online app, which allows patients to enter information about the injury or health condition they require advice on; this information is then reviewed by a doctor (a consultant in emergency medicine), who will contact the patient and either provide advice (and a prescription where necessary) remotely, or will make arrangements for the patient to be seen in person by a Bluezone doctor at HCA Chiswick Outpatient & Diagnostic Centre (HCA), where Bluezone staff have access to HCA's diagnostic and treatment facilities. During face to face consultations at HCA, doctors worked under practicing privilages granted by HCA, and therefore, this aspect of the service did not form part of the inspection.

At the time of the inspection the service only provided face to face consultations from a single site, but planned to expand to provide consultations from further sites in other parts of London and selected areas throughout the rest of England.

How we inspected this service

This inspection was carried out by a CQC Lead Inspector, a member of the CQC medicines team, and two GP Specialist Advisors.

Before the inspection we gathered and reviewed information from the provider. During this inspection we spoke to the Registered Manager, members of the management and clinical teams and representatives from the contractors used to develop the online app and provide the patient records system.

To get to the heart of patients' experiences of care and treatment, we ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Why we inspected this service

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

Are services safe?

Our findings

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

Keeping people safe and safeguarded from abuse

All staff who had contact with patients had received training in safeguarding for both children and vulnerable adults to an appropriate level and knew the signs of abuse. All staff had access to the safeguarding policies, which included details of where to report a safeguarding concern. It was a requirement for the consultants registered with the service to provide evidence of up to date safeguarding training certification.

The service registered children aged under 16, but children could not use the platform themselves; their parent or guardian could contact a doctor for an online assessment on their behalf.

Monitoring health & safety and responding to risks

At the time of the inspection the service had only recently been publicly launched (following several months of piloting using selected individuals); therefore, uptake was low, which allowed for every consultation to be reviewed by the management team. We saw evidence that information gathered as a result of these reviews was discussed at clinical meetings in order to identify risks and areas where systems required further development. The service was aware that this level of review would not be sustainable as the number of consultations increased, and they were in the process of setting up automated audit reports from their records system which would allow them to maintain an oversight of both the use of the service and the clinical care being provided.

Monitoring health & safety and responding to risks

The provider headquarters was located within a small office. The IT system was "cloud" based. Patients were not treated on the premises; doctors either carried-out consultations remotely via the online app or saw patients face to face at their designated clinical facility (under individual practicing privilege arrangements). All staff who worked from the premises were aware of health and safety arrangements specific to the building, including fire safety.

The provider expected that all doctors would conduct consultations in private and maintain the patient's confidentiality. Doctors used their personal laptops to access the service's operating system, which allowed them to communicate with patients via the online app and to access patient records. Both the app and the patient records system were "cloud" based and encrypted.

At the time of the inspection doctors used letter templates to produce prescriptions for patients; the templates were accessed via the service's operating system, and doctors would complete the details of the prescription, send it to the patient or their designated pharmacy, and then save it to the patient's record; where prescriptions were sent directly to patients, these were in hard copy format only, electronic prescriptions were used where prescriptions were sent directly to a pharmacy. We asked the service about the security of patient information within this process, particularly given that doctors used their personal laptops, and we were told that there was an expectation that doctors would delete the prescription document from their laptop as soon as a copy had been saved to the patient's record; however, at the time of the inspection this requirement was not explicit in any of their operating policies. We were told that the management team anticipated that as the demand for the service grew, doctors would be based at one of the hospitals where face to face consultations were provided and use a specific computer which was permanently at that location. Following the inspection, the service provided evidence that they had considered this issue further, including discussions with their clinical governance committee, adding to their risk register and amending their record keeping policy to explicitly outline the requirements in respect of the immediate deletion of all patient identifiable information from laptops. The service also informed us that they were in the process of developing their operating system to allow prescriptions to be generated and sent to the patient or pharmacy directly via the system, without the need for the prescription document to be downloaded.

There were processes in place to manage any emerging medical issues during a consultation and for managing test results and referrals. In the event an emergency did occur during a consultation via the app, the provider had systems in place to alert emergency services using the patient's mobile phone number, who could trace the patient's whereabouts. The service did not routinely establish patients' locations during a consultation.

Are services safe?

At the time of the inspection, the service had only recently been made available to the general public, and therefore, consultation volumes were low which meant that patients were being seen by a doctor immediately after requesting a consultation via the online app. In anticipation of the service becoming busier, there were arrangements in place to enable patients to be triaged when a request for a consultation was received, to ensure that consultations were scheduled according to risk and clinical need.

A range of clinical and non-clinical meetings were held with staff, where standing agenda items covered topics such as significant events, complaints and service issues. Clinical meetings also included case reviews and clinical updates. We saw evidence of meeting minutes to show where some of these topics had been discussed; minutes of the service's monthly clinical governance meetings showed that performance data and detailed reviews of patient care were discussed and that actions were identified and monitored. For example, following a review of the service's antibiotic prescribing a decision was made to develop service-specific antibiotic guidance.

Staffing and Recruitment

There were enough staff to meet the demands for the service and there was a rota for the doctors. Staff could access support from the management team or from external contractors (app developers and representatives from the company providing the patient records system). The doctors were paid on a sessional basis during scheduled shifts and on an hourly basis when providing cover at other times.

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

Potential clinical employees were required by the provider to be currently working in the NHS and be registered with the General Medical Council (GMC). The service had a medical indemnity policy in place to cover each of the doctors (to include cover for video consultations), an up to date appraisal, and certificates relating to their qualification and training in safeguarding.

All doctors working for the service at the time of the inspection had been involved in its set-up and development, and therefore had not required a formal induction. We saw evidence that an induction programme had been developed which would be used to induct new doctors as and when they were recruited.

We reviewed three recruitment files which showed the necessary documentation was available. The doctors could not be registered to start any consultations until the necessary pre-employment checks and induction training had been completed. The provider kept records for all staff and there was a system in place that flagged up when any documentation was due for renewal, such as doctors' professional registration.

Prescribing safety

Doctors working for the service were able to issue a private prescription to patients if this was deemed necessary during a consultation. The service had developed prescribing guidance for doctors which specifically prohibited certain medicines (such as opiates and benzodiazepines) from being prescribed during remote consultations. All medicines prescribed to patients during a consultation were monitored by the provider to ensure prescribing was evidence based.

Once the doctor prescribed the medicine and dosage of choice, relevant instructions were given to the patient regarding when and how to take the medicine, the purpose of the medicine and any likely side effects and what they should do if they became unwell.

As the service was intended for use as an emergency service, they did not initiate prescribing for long-term conditions or medicines which required regular monitoring. Their prescribing policy allowed for repeat medicines (which had been initiated elsewhere) to be prescribed once to a patient, only in a situation where the patient would otherwise be left without the medicines they needed, and only where the medicine to be prescribed fell within the criteria outlined in their prescribing policy.

The service's prescribing policy included details of how the service would safely prescribe unlicenced medicines. At the time of the inspection no unlicenced medicines had been prescribed.

Are services safe?

Prescriptions could be sent to the pharmacy of the patient's choice by email. For patients located within Greater London, the service could arrange for a prescription or the medicine (dispensed via an associated pharmacy) to be delivered by courier for an additional fee.

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

Information to deliver safe care and treatment

On registering with the service, patients were required to provide their address, date of birth and a verified email address. Before patients were able to access the full service (including receiving specific treatment advice or a prescription), they were required to upload two forms of photographic identification and a copy of a utility bill in order that the service could verify their identity. At the time of the inspection the service was handling very small numbers of new registrations and therefore checks of the identity information provided was being done by the consulting doctor. The payment system within the app provided a further identity checking safetynet, as it would not allow an account to be set up if the personal details entered by a new patient did not match their credit card details. The service had plans to adopt identity checking software to replace the manual checks in the future. The consulting doctors had access to the patient's previous records held by the service.

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. Due to the short length of time that the service had been operating, no significant events had occurred; however, we saw evidence of processes being in place for incidents to be reported and learned from. We saw evidence that feedback provided by patients during the piloting of the service was discussed internally in order to make improvements.

Are services effective?

(for example, treatment is effective)

Our findings

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

Assessment and treatment

We viewed examples of medical records that demonstrated that each doctor 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.

Patients completed a form via an online app which included details of their past medical history. Patients were then contacted by a doctor using the contact method of their choice (text chat, voice call or video call). During the consultation doctors completed a set template (including a free text section) as part of the patient's medical notes to record details the patient provided about their medical history, current symptoms, and the outcome of the consultation. We were told that there was no limit to the length of time each consultation lasted. We reviewed anonymised medical records which were complete records. We saw that adequate notes were recorded and the doctors had access to all previous notes.

The doctors providing the service were aware of both the strengths (speed, convenience, choice of time) and the limitations (inability to perform an immediate physical examination) of working remotely from patients. They worked carefully to maximise the benefits and minimise the risks for patients. Clear criteria had been established to identify patients who were unsuitable to use the service; this included patients who were aged under 16 (who could be registered with the service but could not access treatment directly), and those experiencing certain symptoms such as anaphylaxis, acute eye syndromes and stroke. Where a patient was considered unsuitable for the service, they were signposted to the most appropriate source of care. The service's app included a button which would automatically dial 999 to enable patients to easily contact emergency services where necessary.

The service was set up to provide the option of a face to face consultation where necessary at a designated hospital site.

Quality improvement

The service monitored consultations and carried out consultation and prescribing audits to improve patient outcomes. At the time of the inspection the service had only recently launched and therefore the numbers of consultations carried-out were low and allowed the service to review each consultation and prescribing decision. The service was aware that this would not be a sustainable approach to quality assurance going forward as the volume of consultations increased. They were in the process of establishing automated audits and processes for reviewing representative samples of consultations.

Staff training

All newly recruited staff had to complete induction training which consisted of an introduction to internal policies and procedures and training on the online consultation platform. Staff also had to complete other training on a regular basis including safeguarding and information governance. The service manager had a training matrix which identified when training was due.

The service had a system of annual appraisal in place; however, at the time of the inspection the service had not been operating for a full year and therefore no formal appraisals had been undertaken.

Coordinating patient care and information sharing

When a patient registered with the service they were asked to provide details of their registered GP. Where the patient chose not to provide this information, they were further prompted to provide it every time they logged onto the app. Where the patient provided their GP's details, with the patient's consent, the service sent a summary of the treatment provided to the GP following each consultation. If a patient did not consent to information being shared with their GP, the consulting doctor would discuss this decision with them; the consulting doctor would take this into account when deciding on the type of treatment that was safe and appropriate to provide (e.g. whether it was safe to provide a prescription); this arrangement was in line with General Medical Council guidance on the sharing of information with patients' registered GPs.

Where diagnostic tests were required, the patient would be directed to attend the designated hospital site which provided phlebotomy, blood testing and clinical imaging services.

Supporting patients to live healthier lives

Are services effective?

(for example, treatment is effective)

An online blog was available on the service's website which provided advice about topics such as treating common minor illnesses and health screening.

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 doctors undertook remote consultations via the online app in a private room where they would not be disturbed. The service was intending to base their doctors in consulting rooms at their designated hospital sites as the service expanded.

We did not speak to patients directly on the day of the inspection; however, we reviewed the service's latest survey information and feedback about the service which had been made directly to CQC. The service had received feedback from 14 patients, mainly during their piloting phase; all patients who commented about doctors were positive about the care provided to them. Four patients provided feedback directly to CQC about the service, and all were positive about the care they had received.

Involvement in decisions about care and treatment

Patient information guides about how to use the service and technical issues were available. The service had included an "easy read" version of their terms and conditions on their website to ensure that patients had the information they needed about the service prior to signing up. Patients who wanted to ask a question about the service could do so via the online app's "chat" function which put them directly through to a doctor.

Patients had access to information about the doctors working for the service; as the service was designed to deliver an urgent care service, patients requesting a consultation would be put through to the next available doctor; there was no option for patients to request a specific doctor.

Following a consultation, all patients were sent a summary record of their consultation.

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 Bluezone service was offered via an online app which allowed patients to access an emergency medicine consultant, and where necessary, arrange to see a consultant face to face at a private hospital in West London. Patients registered with the service via the app, where they could choose either a temporary membership (allowing access to the online service for 72 hours, to allow for the initial consultation plus any follow-up that may be required) or annual membership (which allowed unlimited access to the online service). Face to face appointments carried an additional charge. Charges associated with using the service were clearly set out on the service's website.

The online service was available from 8am to 11pm every day. When the service was closed (or if it was unavailable for any other reason), a screen was displayed to users, providing details of other sources of emergency medical advice.

Once a patient had registered with the service and their identity had been verified, they could make contact with the service via the online app, where they could enter details of their symptoms and select their preferred method of contact (text "chat", voice call or video call) and a doctor would contact them for a consultation. At the time of the inspection the service had only recently launched for public use, and therefore the number of consultation requests was low and most patients were contacted within a few minutes of submitting a consultation request. The service had identified that there would be the need for consultation requests to be triaged as the service became busier, to ensure that patients requiring more urgent care were prioritised; they were in the process of developing this process.

During a consultation with a patient the doctor would provide them with clinical advice, and where necessary, direct them to a more appropriate source of care (e.g. to their registered GP or to their local accident and emergency department). There was no time limit to consultations with patients. Where it was appropriate to issue a prescription, this could be sent to the pharmacy of the patient's choice by email. For patients located within Greater London, the service could arrange for a prescription or the medicine (dispensed via an associated pharmacy) to be delivered by courier for an additional fee.

Where it was necessary for the patient to be seen face to face by a doctor or to undergo diagnostic tests, patients could visit a designated hospital in West London. The service intended to expand by adding further locations throughout England where patients could be seen face to face.

All doctors working for the service were located in the UK. Patients outside of the UK could access the service, but only patients who were located in the UK could receive specific medical advice and treatment or a prescription.

Tackling inequity and promoting equality

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

Patients could access a brief description of the doctors available, but there was no option for patients to choose the doctor they wished to consult with.

Managing complaints

Information about how to make a complaint was available on the service's web site. The provider had developed a complaints policy and procedure. The policy contained appropriate timescales for dealing with the complaint. There was escalation guidance within the policy.

At the time of the inspection the provider had not received any formal complaints; however, we saw evidence that processes were in place to ensure that complaints would be handled in line with their complaints policy and that learning could be shared. We saw evidence that the service had addressed areas of negative feedback received from patients who were involved in trialling the service during the pilot phase.

Consent to care and treatment

There was 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; however, we observed that it was not immediately clear from the information on the website that the service was only providing a face to face service from a single location in West London, and therefore there

Are services responsive to people's needs?

(for example, to feedback?)

was a chance that patients from outside the area could register and pay for the service without realising that they would only be able to access remote consultations. Following the inspection, the service amended the landling page of its website to state clearly that face to face consultations were only available from the Chiswick site.

The website had a set of terms and conditions (including a version written in “easy read”) and details on how the patient could contact them with any enquiries.

All doctors had an understanding of the Mental Capacity Act 2005. Staff understood and sought patients’ consent to care and treatment in line with legislation and guidance. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

Are services well-led?

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

Our findings

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

Business Strategy and Governance arrangements

The provider told us they had a clear vision to work together to provide a high quality responsive service that put caring and patient safety at its heart. We reviewed business plans that covered the next four years which outlined how the service planned to expand, including plans to be able to provide face to face consultations to patients over a wider geographical area.

There was a clear organisational structure and staff were aware of their own roles and responsibilities. There was a range of service specific policies which were available to all staff. These were reviewed and updated when necessary.

There were a variety of daily, weekly and monthly checks in place to monitor the performance of the service. At the time of the inspection records of all consultations were reviewed, as the service was newly established and therefore the numbers of consultations was low; the service was in the process of establishing processes for checking samples of consultations as uptake increased. Any urgent issues arising from these checks was disseminated to staff immediately. Other issues were used to produce a monthly report that was discussed at monthly clinical governance meetings; this ensured a comprehensive understanding of the performance of the service was maintained.

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

Care and treatment records were complete, accurate, and securely kept; however, at the time of the inspection the service did not have arrangements in place to ensure that records could continue to be stored in line with guidance should they cease to trade. Following the inspection the service undertook to put necessary arrangements in place and added this issue to its risk register.

Leadership, values and culture

The Clinical Director had responsibility for any medical issues arising. They attended the service regularly; when they were not present at the service's headquarters they could be contacted by phone or email; there were also other senior staff, both clinical and non-clinical, who could provide support to staff.

We saw that the clinical team were in regular contact, via both formal clinical meetings and using email and a dedicated WhatsApp group in order to share information and request advice.

Important information, such as changes to policies, was communicated via the service's operating system. The system had the facility to flag updated documents and mark them once they had been read by staff in order to enable the management team to be assured that staff were remaining up to date with changes to the service.

The service had an open and transparent culture. We saw that there were operational policies in place which outlined the process for reporting and recording unexpected or unintended safety incidents; the policy and supporting reporting tools were available to all staff via the service's operating system. At the time of the inspection, due to the short time the service had been operating, they had not had any such incidents occur.

Safety and Security of Patient Information

Systems were in place to ensure that patient records were stored and kept confidential. There were policies and IT systems in place to protect the storage and use of all patient information. The service could provide a clear audit trail of who had access to records and from where and when. The service was registered with the Information Commissioner's Office. There were business contingency plans in place to minimise the risk of losing patient data.

Seeking and acting on feedback from patients and staff

Following each consultation patients were invited to provide feedback via the online app. We saw evidence that this feedback was collated and discussed at the service's monthly clinical governance meetings, and that comments were used to prompt improvements to the service.

There was evidence that the doctors 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.

Continuous Improvement

Are services well-led?

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

The service consistently sought ways to improve. All staff were involved in discussions about how to run and develop the service, and were encouraged to identify opportunities to improve the service delivered.

We saw minutes of staff meetings where previous patient interactions and consultations were discussed. From discussions with clinical staff during the inspection, we found evidence that staff felt supported in their roles and that the service's "no blame" culture led to staff feeling confident that if they made a mistake they would be supported and that it would be used as a learning opportunity.

At the time of the inspection the service had only been operational for a short time and had only a small amount of data with which to review and audit; the management team had therefore been looking at all consultations in order to review patient care. They were aware that this would not be a sustainable approach as the number of consultations increased, and they were therefore in the process of gradually setting up automated audits which would provide them with the information they needed in order to monitor the quality of patient care, patient satisfaction and other operational data.