Q doctor

Inspection 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.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

Letter from the Chief Inspector of General Practice
We rated this service as Good **overall.** (Previous inspection 3 August 2018)

The key questions are rated as:

Are services safe? – Good Are services effective? – Good Are services caring? – Good Are services responsive? – Good Are services well-led? – Good

We carried out an announced comprehensive inspection at Q doctor on 4 September 2019 as part of our rated inspection programme.

The provider has a contract with Carerooms.com (Carerooms) and provides private online video GP consultations as part of a service agreement between Q doctor and individuals who pay a fee to Carerooms. Carerooms provides patients with a computer tablet device which has the Q doctor app pre-loaded onto it for them to sign up for the service. Patients who pay for the Carerooms service are able to book a Q doctor private GP video consultation. In addition, the provider does a number of activities that fall out of scope of CQC regulation. For example, the provider supplies an online video GP locum service to NHS providers. The responsibility for the oversight of regulated activities carried out by these locum GPs falls to the individual practices. Q doctor also supplies NHS services with the IT systems to enable them to undertake video consultations. The elements of the service that do not fall under CQC regulation were not considered or assessed as part of this inspection.

At this inspection we found:

- The service had good systems to manage risk so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes.
- The service had systems in place that enabled them to review the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- Staff involved and 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 was a strong focus on continuous learning and improvement at all levels of the organisation.

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 GP specialist adviser, a member of the CQC medicines team and a second CQC inspector.

Background to Q doctor

Q doctor was registered with CQC on 6 September 2017. Q doctor is an online GP consultation service to patients who have signed up to Carerooms. Carerooms is a service which enables people to be discharged from hospital back into the community into hosted accommodation with additional support. People who use the services of Carerooms can choose to pay for access to the Q doctor service. This allows patients to consult with a GP via video link. Patients can access the service via a computer tablet device provided by Carerooms. However, we were told that this online service had not yet been utilised by anyone as part of the Carerooms service.

At our last inspection the service offered direct private video consultations where members of the public could sign up directly to access Q doctor on a per consultation fee or subscription basis. The service was also available in some pharmacies where video consultations were undertaken in a private room at the pharmacy. The provider had undertaken 31 private video consultations via these channels since the last inspection. However, these services were no longer operational at the time of this inspection and the only aspect of the service that fell within the remit of CQC regulation were the consultations provided via Carerooms.

Prescriptions generated as a result of any consultations are sent electronically to the provider's nominated pharmacy. The pharmacy then sends the prescription to the patient by post.

The service also provides an online GP locum service, whereby GP practices pay for a locum session with one of the service's GPs, which is carried-out via video link. When Q doctor is delivering this aspect of its service, care for patients is delivered under the governance arrangements of the commissioning GP practice who retain responsibility for the care provided, with Q doctor acting as a locum agency; therefore, we did not inspect this aspect of the service.

How we inspected this service

This inspection was carried out on 4 September 2019; the inspection team consisted of a CQC Lead Inspector, GP Specialist Advisor, a member of the CQC medicines team and another CQC inspector. Before the inspection we gathered and reviewed information from the provider. During the inspection we spoke to the Registered Manager, a member of the management and the Chief Medical Officer who was also a clinician working for the service.

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

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

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

Good

Are services safe?

We rated safe as Good because:

Keeping people safe and safeguarded from abuse

Staff employed at the headquarters had received training in safeguarding and whistleblowing and knew the signs of abuse. All staff had access to the safeguarding policies which detailed where to report a safeguarding concern. All the GPs had received adult and level three child safeguarding training. It was a requirement for the GPs registering with the service to provide evidence of up to date safeguarding training certification.

The service did not treat children; however, staff were aware of the possibility that they could identify child safeguarding issues in the course of their interactions with adults, and therefore they had a child safeguarding policy in place to support staff in dealing with these issues. The policy contained the contact details for child safeguarding teams at each local authority in the UK. The online consultation system provided GPs with details of local safeguarding contacts in the area that the patient was located in. The consultation system also enabled GPs to raise safeguarding alerts within the system which would be sent to the service's safeguarding leads.

Monitoring health & safety and responding to risks

The provider headquarters was located within modern offices which housed the IT system and a range of administration staff. Patients were not treated on the premises, as GPs carried out the online consultations remotely; usually from their home. All staff based in the premises had received training in health and safety including fire safety. The provider expected that all GPs would conduct consultations in private and maintain the patient's confidentiality.

Each GP used an encrypted, password secure laptop to log into the operating system, which was a secure programme. The suitability of GPs' home working environment was assessed as part of their induction.

There were processes in place to manage any emerging medical issues during a consultation and for managing test results and referrals. The service was not intended for use by patients with either long term conditions or as an emergency service. Patients using the online system would be required to confirm before the consultation began that they were not seeking emergency treatment. In the event an emergency did occur, the provider had systems in place to ensure the location of the patient was known at the beginning of the consultation, so emergency services could be called.

Patients seeking an appointment via Carerooms were placed into a virtual "waiting room" and would aim to be be seen by a doctor within a maximum of 20 minutes.

If a patient was assessed as requiring face to face medical attention, they were signposted appropriately either to A&E, to their own registered GP, or to a walk-in centre.

Where patients were referred to a walk-in centre, the patient records system viewed by the service's consulting GPs had the facility to search using the patient's address to send them an interactive map to direct them to the nearest walk-in centre to them.

A range of clinical and non-clinical meetings were held with staff, where standing agenda items covered topics such as significant events, complaints and service issues. Clinical meetings also included case reviews and clinical updates. We saw evidence of meeting minutes to show where some of these topics had been discussed. Given that there had been no private consultations since the cessation of the direct or pharmacy service offering, clinical meetings where cases could be raised and discussed had stopped. However, we were told that the these would be instigated when more people started having private consultation via Carerooms.

Staffing and Recruitment

There were enough staff, including GPs, to meet the demands for the service and there was a rota for the GPs. There was a support team available to the GPs during consultations and a separate IT team. The prescribing doctors were paid on an hourly basis. The provider had a selection and recruitment process in place for all staff. There were a number of checks that were required to be undertaken prior to commencing employment, such as references and Disclosure and Barring service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)

The service held a professional indemnity policy, which covered all clinicians who worked for them. One of the terms of this policy was that each individual covered

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

Newly recruited GPs were supported during their induction period and an induction plan was in place to ensure all processes had been covered. We were told that GPs did not start consulting with patients until they had successfully completed several test scenario consultations.

We reviewed two recruitment files which showed the necessary documentation was available. The GPs could not be registered to start any consultations until these checks and induction training had been completed.

Prescribing safety

All medicines prescribed to patients during a consultation were monitored by the provider to ensure prescribing was evidence-based. If a medicine was deemed necessary following a consultation, the GPs could issue a private prescription to patients. The GPs could only prescribe from a set list of medicines which the provider had risk-assessed. There were no controlled drugs on this list.

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

The provider had a restricted formulary and policy was to issue a maximum of 10 days' supply of medicines except in exceptional circumstances. The CMO reviewed all private prescribing to ensure it complied with the provider's policies and good practice.

The service was not intended for use by patients with either long term conditions or as an emergency service however, GPs were able to prescribe for long term conditions that required monitoring such as hypertension, asthma and hypercholesterolaemia. The provider managed the risk of this prescribing by not providing more than 10 days' supply and, where patients gave consent, informing the regular NHS GP of this prescribing.

The service encouraged good antimicrobial stewardship by only prescribing from a limited list of antibiotics which was based on national guidance. The prescribing policy included an embedded link to the Royal College of General Practitioners antibiotic toolkit.

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

We were advised that electronic prescriptions were sent to a nominated pharmacy and dispensed and delivered to the patient within 24 hours.

Information to deliver safe care and treatment

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

Management and learning from safety incidents and alerts

We were shown records of the action taken in response to recent patient alerts and the service had a system for reviewing and cascading relevant alerts to all clinicians working at the service.

There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. All incidents were risk rated. We reviewed three that had arisen in the course of the provider's work supplying locum services to NHS providers 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, the provider had experienced previous instances where patients not associated with the Carerooms service, who were under the age of 18, had attempted to access care. As a result, the provider had rolled out additional training for receptionists and shared learning with GPs to ensure that they were vigilant when checking patients' identification.

Good

Are services effective?

We rated effective as Good because:

Assessment and treatment

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

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

Patients completed an online form which included their past medical history. There was a set template for consulting GPs to complete for the consultation, which included details of the reasons for the consultation, the outcome, and any notes about past medical history and diagnosis. We reviewed medical records which were complete records. We saw that adequate notes were

recorded. All GPs were able to access the consultation history for patients who had used the service before.

The GPs providing the service were aware of both the strengths (speed, convenience, choice of time) and the limitations (inability to perform physical examination) of working remotely from patients. They worked carefully to maximise the benefits and minimise the risks for patients. If

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

The service monitored consultations and carried out consultation and prescribing audits to improve patient outcomes. Although much of the quality improvement activity focused on the part of the service which supplied locums to NHS providers; we were assured that these quality improvement activities could be extended and expanded upon in the event of an increase in private consultations.

Quality improvement

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

• The service used information about patients' outcomes to make improvements.

• The service took part in quality improvement activity, for example audits, reviews of consultations and prescribing trends. Due to the small number of consultations being carried-out at the time of the inspection, all 31 consultations that fell within the scope of CQC regulation, including prescriptions issued, were being reviewed by the Chief Medical Officer (CMO). This enabled quality to be monitored and improvements made where necessary.

Staff training

All staff had to complete induction training which consisted of training on the online system and familiarising with the service's policies and procedures. Staff based at the service's offices also had to complete training in health and safety, and fire safety. Clinical staff who worked remotely had to complete on-boarding exercises including working through example clinical scenarios, they also had their home working environment assessed to ensure that it was suitable to maintain patient confidentiality and provide a professional appearance. This could be periodically reviewed and monitored by staff at Q doctor and we saw that reviews had been undertaken.

An induction log was held, and clinical staff were not permitted to carry-out consultations until they had completed a full induction. Staff also had to complete other training on a regular basis including adult and child safeguarding (child level 1 for administrative staff and child level 3 for clinical staff), mental capacity and data security. The service maintained a training matrix which was reviewed monthly and flagged any training that was due or documentation that needed to be rechecked or was due for renewal. If any clinical staff failed to keep up to date with required training or if other necessary documents (such as professional indemnity certificates) expired, the clinician would be suspended from the service until such time as they completed training or provided the necessary updated documentation. We saw examples of this process being effectively employed.

Staff told us they received excellent support if there were any technical issues or clinical queries and could access policies. When updates were made to the IT systems or to the service's policies, all staff received updates and any

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

All staff received regular performance reviews. All the GPs had to provide evidence of having completed their own annual appraisals before being considered eligible at recruitment stage. The service carried out in-house reviews for clinical staff.

Coordinating patient care and information sharing

When a patient registered with the service, they were encouraged to provide details of their registered GP; the online registration form had an integrated search facility to allow patients to search for their registered NHS GP using their address, this ensured that patients were not prevented from providing their GP's details as a result of them being unsure of the surgery name or address. When the patient booked an appointment with the service they were asked each time whether they consented to the details of the consultation being shared with their registered GP. Patients had to provide consent to share this information in order for them to access Q doctor services. Consultations were shared with the patient's GP via Docman.

The service did not order blood tests for patients; if blood tests were required in order to treat a patient, they were advised to visit their registered GP or NHS walk-in centre.

The service had not undertaken any referrals since our last inspection, but we were told that these could be made by the service to external specialists or services; in which case any resulting correspondence would be sent to the patient's registered NHS GP rather than to Q doctor.

Supporting patients to live healthier lives

The service identified patients who may be in need of extra support and GPs could signpost patients to sources of advice and information as necessary. The service could send patients links to external sources of information via the online consultation system that patients could then refer back after the consultation had ended.

In their consultation records we found patients were given advice on healthy living as appropriate.

Good

Are services caring?

We rated caring as Good because:

Compassion, dignity and respect

We were told that the GPs undertook video consultations in a private room and were not to be disturbed at any time during their working time. As part of the induction process, the provider checked each GP's working environment to ensure that it was suitable. The provider had the ability to check the consultation environment using software which captures a still photograph of the area to ensure this remained appropriate. A review had been conducted which focused on this.

We did not speak to patients directly on the day of the inspection. However, we reviewed the service's latest survey information. At the end of every consultation, a pop-up appeared on the patient's screen which allowed them to score the service they received out of five and to submit free-text comments. This feedback was used by the service to provide feedback to the consulting GPs and to make changes where necessary. Any scores of three or under were automatically transferred to the service's complaints spreadsheet to allow for trends to be spotted.

We saw evidence that the issues identified were discussed in the quarterly clinical governance meeting. The data provided by the service showed that in the past 12 months, 14 out of the 31 private consultation completed since our last inspection patients had provided feedback and rated the service five stars out of five.

Involvement in decisions about care and treatment

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

At the time of the inspection patients did not have access to information about the GPs working for the service; however, they could book a consultation with a GP of their choice. For example, private patients could choose whether they wanted to see a male or female GP. The GPs available could speak a variety of different languages and a language translation service was available to be used for translation where required. The service was in the process of developing translation software which could be used on the chat text function which enabled patients to type questions in addition to the video functionality.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

Responding to and meeting patients' needs

Consultations could be provided on a flexible basis. The service had the capacity to provide online video GP consultations 7 days per week between 8 am and 8 pm.

Patients could access consultations via an online link or app using a computer tablet device provided by Carerooms. Patients would select a suitable time for an appointment and would be placed in a virtual waiting room when they logged in at that time to wait until the GP was available.

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

Patients who had a medical emergency were advised to ask for immediate medical help via 999 or if appropriate to contact their own GP, NHS 111 or an NHS walk-in centre. GPs could alert staff via the chat function if a person was having an emergency and their next appointment would be reallocated to provide them with sufficient time to deal with the emergency.

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

The provider made it clear to patients what the limitations of the service were. Information on their website explained clearly the types of problems they were able to treat. The service only accepted consultation requests for patients located in the UK. We saw examples of incidents where patients had attempted to consult from abroad and the provider had raised this as a significant event and reiterated to staff the requirement for checking a patient's current location.

Tackling inequity and promoting equality

The provider offered consultations to anyone aged 18 years and over who had signed up to receive Q doctor service via Carerooms. No demographic group was discriminated against.

Private patients could choose either a male or female GP.

Managing complaints

Information about how to make a complaint was available on the service's web site. The provider had developed a complaints policy and procedure. The policy contained appropriate timescales for dealing with the complaint. There was escalation guidance within the policy. We reviewed the complaint system and noted that comments and complaints made to the service were recorded, this included any patient satisfaction scores of three or below out of five.

The provider was able to demonstrate that the complaints we reviewed were handled correctly and patients received a satisfactory response. There was evidence of learning as a result of complaints, changes to the service had been made following complaints, and had been communicated to staff.

Consent to care and treatment

All staff had received training about the Mental Capacity Act 2005 and were aware of the relevant issues and legislation around consent and capacity.

Good

Are services well-led?

We rated well-led as Good because:

Business Strategy and Governance arrangements

The provider told us they had a clear vision to work together to provide a high-quality responsive service that put caring and patient safety at its heart, and that worked alongside and in support of the NHS. We reviewed business plans that covered the next five years, in which the service outlined its plans to build services to complement and support the NHS via the provision of its online locum service and providing online consultations for patients contacting the NHS 111 service.

There was a clear organisational structure and staff were aware of their own roles and responsibilities. There was a range of service specific policies which were available to all staff. These were reviewed and updated when necessary; staff were alerted when policies were updated, and staff were required to confirm that they had read the updated policy.

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

Care and treatment records were complete, accurate, and securely kept. The service had arrangements in place to store clinical records in line with legislation should they cease trading.

Leadership, values and culture

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

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

The service had an open and transparent culture. We were told that if there were unexpected or unintended safety incidents, the service would give affected patients reasonable support, truthful information and a verbal and written apology.

Safety and Security of Patient Information

Systems were in place to ensure that all patient information was stored and kept confidential. There were policies and IT systems in place to protect the storage and use of all patient information. The service could provide a clear audit trail of who had access to records and from where and when. The service was registered with the Information Commissioner's Office. The service's data security systems had been assessed as part of their bid to take part in the NHS 111 service pilot, and we saw evidence that they had received approval from NHS Digital that their systems met the required security standard.

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

Seeking and acting on feedback from patients and staff

Patients could rate the service they received. Patient feedback was constantly monitored; any ratings of three out of five or below were automatically captured on a spreadsheet and reviewed by the management team.

From the data we were shown, patient feedback was overwhelmingly positive. GPs were able to provide feedback about the quality of the operating system and any change requests were logged, discussed and decisions made for the improvements to be implemented.

The provider had a whistleblowing policy in place. (A whistle blower is someone who can raise concerns about practice or staff within the organisation.) The Chief Executive was the named person for dealing with any issues raised under whistleblowing.

Continuous Improvement

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

Good

Are services well-led?

We saw minutes of staff meetings where previous interactions and consultations were discussed.

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

There was a quality improvement strategy and plan in place to monitor quality and to make improvements, for example, through clinical audit. The service monitored consultations and carried out consultation and prescribing reviews to improve patient outcomes. Reviews including areas prescribing of antibiotics, consultations, and clinical areas were completed.

In addition to plans to develop and expand the business, the service had also identified a number of areas for development in order to make the service safer for patients; for example, the provider was developing translation software to enable patients to communicate using a text function during consultations.