STADN Limited

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	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Not sufficient evidence to rate**
Are services caring?	**Not sufficient evidence to rate**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

Overall summary

Letter from the Chief Inspector of General Practice

We rated this service as Requires improvement overall. The location had not previously been inspected.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Not sufficient evidence to rate

Are services caring? – Not sufficient evidence to rate

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at STADN Limited over two days on 10 and 11 September 2019 as part of our inspection programme.

STADN Limited was established in 2006 and registered with the Care Quality Commission in 2014. It is run by two directors who are based at the management offices. It currently provides a remote clinical advice service delivered by doctors via telephone. It had recently stopped providing video consultation services.

This service is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some general exemptions from regulation by CQC which relate to particular types of service and these are set out in Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At STADN Limited, some services are provided to patients under arrangements made by their employer, by an insurance provider with whom the service user holds an insurance policy (other than a standard health insurance policy). STADN Limited also provides: remote clinical advice to other medical professionals without consulting with their patients directly, remote clinical advice to providers who are based and treat patients overseas; clinical and call handling solutions for other health care organisations including NHS commissioners. These types of arrangements are exempt by law from CQC regulation.

Therefore, at STADN Limited, we were only able to inspect the services which are provided in England and not arranged for patients by their employers or an insurance provider with whom the patient holds a policy.

At this inspection we found:

•The provider had not notified CQC of a change of address and had not ensured CQC was provided with accurate contact details for the registered manager and nominated individual.

•The provider did not require clinicians to make written notes of calls to the telephone advice service and did not have a process in place to manage any notes produced.

•Arrangements in place to oversee the secure storage of recordings of calls made to the service were not effective.

•The provider had separate prescribing policies for the different services provided but it was not clear which policy applied to each service. The service was not undertaking any prescribing activity at the time of this inspection.

•Doctors were trained to deliver the service in a way that respected privacy and dignity.

The area where the provider **must** make improvement is:

•Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The area where the provider **should** make improvement is:

•Review systems used to manage personnel records to ensure managers can be assured all required pre-employment checks are in place and required mandatory training is up to date.

•Put a system in place to document home working risk assessments undertaken by staff working remotely, to ensure their working environment is safe.

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 STADN Limited

STADN Limited was established in 2006 and currently provides access to doctors via telephone for self-funding patients and employees or members of other organisations with whom the service has contracts in place.

Prior to this inspection, the majority of provider's activity related to the delivery of telephone and video consultation services for a single insurance company client using software and infrastructure owned by the client. Medical records relating to this service were managed and stored on the client's computer servers, to which the provider no longer had access because this contract had been terminated.

At the time of this inspection, the service was in the final stages of restructuring the organisation and had ceased providing video consultations. A pay-per-call telephone advice service currently represented the majority of those regulated activities which are within the scope of registration. The pay-per-call telephone service is limited to providing medical advice only and a pre-recorded announcement message at the beginning of each call advises patients the service is not designed to replace a face to face consultation with a medical professional. The message also states the service is not an emergency service and does not provide a diagnosis or prognosis. Patients requiring urgent treatment are advised to dial 999. Patients using the telephone advice service pay a one-off consultation each time they use the service, and this can be done by credit card or by using a premium rate telephone number. The provider does not prescribe medicines to people using the pay-per-call telephone service. Consultations with employees of corporate clients and members of insurance companies are funded according to the respective terms agreed with each organisation.

The telephone advice service is available twenty-four hours per day. People who have used the system previously can request an appointment with a specific doctor using the doctor's unique PIN number or enter the call queuing system for the next available clinician.

Doctors, working remotely, provide telephone advice to patients. At the time of this inspection, doctors did not make referrals to other services and did not carry out any prescribing activity.

The service's clinical team consists of a clinical director who is an Accident and Emergency (A&E) consultant, and five self-employed doctors, three of whom also work as GPs in NHS practices and two of whom are A&E doctors who also work in hospitals. There is a registered manager who is also a director of the organisation and six non-clinical staff.

STADN Limited, the provider, registered with CQC in May 2014 to provide the following regulated activities; transport services, triage and medical advice provided remotely and treatment of disease, disorder and injury. The service registered its current registered location at: South Terrace, Nova South, 160 Victoria Street, London, SW1E 5LB in January 2019. However, when this inspection was announced, the provider told us it had relocated to new premises located at China Works, 100 Black Prince Road, Vauxhall, SE1 7SJ. The provider had not made an application to CQC to change location details prior to relocating. This inspection was carried out at the premises in Vauxhall.

How we inspected this service

Before the inspection we requested information from the provider. However, because the provider had relocated to a different address without making arrangements to forward incoming mail, they did not receive the request.

During this inspection we spoke to the Registered Manager and members of the management and administration team.

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.

Requires improvement

Are services safe?

We rated safe as Requires improvement because the provider had separate prescribing policies for the different services provided and it was not clear how the provider ensured doctors would follow the correct prescribing policy. Although the provider was not currently carrying out any prescribing, it was registered to carry out the regulated activity of treatment of disease, disorder or injury which meant it could resume prescribing at any time.

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 and how to report a safeguarding concern. We noted the policies contained a table in which a clinician was able to insert details of the safeguarding authority in the area in which they worked. However, unlike NHS GP practices, the service provided care and treatment for adults who resided throughout the UK and the service recognised it was important that any necessary contact was direct with the appropriate local authority safeguarding team where a patient resided. The provider's safeguarding policies directed clinicians to raise any safeguarding concern directly with the safeguarding lead within a maximum of two hours from first having a concern except in an emergency in which case an emergency call to police was recommended. We saw the safeguarding policy included pro-forma documents to help staff gather and record information about a concern. The safeguarding lead was able to demonstrate how they would identify and contact local authority adult and children safeguarding teams throughout the UK.

All the doctors had received adult and level three child safeguarding training. It was a requirement for the doctors registering with the service to provide evidence of up to date safeguarding training certification.

The service did not provide remote clinical advice by telephone to people aged under eighteen years.

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 doctors carried out consultations remotely; usually from their home. One member of headquarters staff had a background in health and safety management and held responsibility for overseeing arrangements in this area. All staff based in the premises had received training in health and safety including fire safety.

The provider expected all doctors would conduct consultations in private and maintain patient confidentiality and provided detailed guidance about how this was to be achieved. For instance, doctors were required to work in a private room and advised to use a headset rather than a conference speaker. Each doctor used a two-step authentication system to log into the telephone system when carrying out telephone consultations. Doctors were required to complete a home working risk assessment to ensure their working environment was safe, however we did not see evidence to show these had been completed.

The telephone advice service was not intended for use by patients with acute or long-term conditions or as an emergency service and this was made clear during a pre-recorded announcement which was played before every consultation. Patients with such requirements were advised to contact their own GP or dial 999 as appropriate.

A range of clinical and non-clinical meetings were held with staff, where standing agenda items covered topics such as significant events, complaints and service issues. Clinical meetings also included case reviews and clinical updates. We saw evidence of meeting minutes to show where some of these topics had been discussed, for example discussion about complaints and changes to the services provided.

The provider had carried out a risk assessment to determine whether it should be a requirement to verify the identity and telephone number of callers accessing the telephone medical advice service. The provider had concluded, as it did not provide an emergency service, diagnoses or prognoses, it did not prescribe medicine or treatment and did not make referrals to other providers, the risks associated with not confirming identity or contact details were low. In addition, the provider told us many of the callers contacted the service to ask questions about general health, including questions about sexual health and the requirement to self-identify could present a barrier to receiving important advice about matters which impacted public health. However, the provider had given

doctors guidance about managing potential emergency situations, for instance people describing thoughts of self-harm or people showing signs of addiction to premium rate telephone services.

Staffing and Recruitment

There were enough staff, including doctors, to meet the current demands for the service. Doctors had contact details for the clinical director and were encouraged to make contact if they had any clinical queries or concerns about any aspect of the service.

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. Doctors could not be registered to start any consultations until these checks and induction training had been completed. We reviewed five recruitment files which showed the necessary documentation was available although we found these files were not well managed. For instance, one file did not include details of a DBS check although the clinical director was able to produce evidence showing this had been undertaken. Similarly, we found another file did not include details of references for one doctor, but these were also found in another part of the filing system.

Potential clinical employees were required to be currently working in the NHS and be registered with the General Medical Council (GMC) with a license to practice, the service also checked GPs were on the NHS performers list. The National GP Performers List provides reassurance for the public that GPs practicing in the NHS are suitably qualified, have up to date training, have appropriate English language skills and have passed other relevant checks such as with the Disclosure and Barring Service (DBS) and the NHS Litigation Authority.

Doctors worked on a self-employed basis. Self-employed doctors were required to provide evidence to the service of appropriate medical indemnity cover for their work with the service. Any doctor whose existing indemnity arrangements did not cover their work with the service were included in separate arrangements made by the provider.

Newly recruited doctors registered with the service had to receive specific induction training prior to treating patients. Supporting material was available to new doctors, including: a training manual which included topics such as how to set up the IT system and how to develop remote consultation skills.

Prescribing safety

At the time of this inspection, the service was not undertaking any prescribing activity because it did not prescribe medicines to people accessing the service by telephone. Prior to speaking with a clinician, people using the telephone service were told the service was not an emergency service and did not provide a diagnosis or prognosis. Callers with medical emergencies were advised to hang up and dial 999 or the emergency number of the country from which they were calling.

Although the provider was not currently providing any services which involved prescribing, we reviewed how it had prescribed in the past. The provider had three different prescribing policies in place and these referred to three different services previously provided. However, we found it was not obvious which prescribing policy was to be used for each service because they were not clearly titled. One of these policies governed prescribing policy for a service which was outside of the scope of registration, one was to govern prescribing to people accessing the service for a video consultation under a health insurance policy whilst the third policy governed prescribing for people accessing video consultations on a pay-per-use basis.

The two prescribing policies which covered services within the scope of registration contained certain exclusions. Specifically, the provider did not prescribe medicines to anyone under the age of 18, did not issue repeat prescriptions and did not prescribe medicines to treat long-term conditions or any other condition that required ongoing management by a person's registered GP. Both prescribing policies excluded prescribing for any newly diagnosed condition and prescribing any medicine which required blood profiling or regular monitoring. In addition, doctors working for the service could not prescribe controlled drugs, unlicensed medicines or any analgesic

medicines requiring monitoring or supervision. Both policies also contained limited inclusion criteria, such as: limiting prescribing to a maximum one-month supply of emergency contraception or a one-month supply of certain acne medicines. Prescribing policy also required that doctors only prescribe antibiotics if they could be satisfied a correct differential diagnosis could be made without the need for a physical examination.

We looked at twenty sets of consultations notes for video consultations undertaken prior to the provider ceasing this service and found four of these had resulted in a prescription being issued. Each of these prescriptions complied with the exclusion criteria outlined in the prescribing policy.

Prescribing was actively monitored when it had been undertaken, with every prescription being reviewed and countersigned by the clinical director prior to being issued. The provider also carried out regular prescribing audits and undertook one to one meetings with doctors during which prescribing performance was discussed.

There were protocols in place for verifying the identity of patients who had used the previous offered video consultation service which were the only consultations where prescribing was allowed. Patients contacting the service through their insurance provider had their identity verified by the insurer prior to the call being passed to the provider, a process referred to as a 'warm transfer'. People contacting the service directly were required to use a credit or debit card to pre-allocate funds before the consultation began and this involved an identity verification process managed by a third party. Where a doctor had any concerns about the identity of a person using the service, they would ask for additional photographic evidence and request this be shown clearly to the camera.

We were advised that patients could nominate a pharmacy where they would like their prescription dispensed. Alternatively, the prescription could be dispensed and delivered direct to the patient. There were systems in place to ensure that the correct person received the correct medicine: patients were required to provide identification when collecting medicines from pharmacies, and upon receipt for delivered medicines.

Information to deliver safe care and treatment

The provider did not require people using the pay-per-call telephone advice service to verify their identity. The provider told us it made it clear to people using the service that no diagnosis or prognosis would be provided and that it was not designed to be a replacement for a face to face consultation with a medical professional.

There were protocols in place for verifying the identity of patients who had used the video consultation service when this had been provided.

Some patients using the service through an insurance plan also included other family members on their policies, but this was managed by the insurance company. Family members requesting consultations were obliged to make contact through the insurance company who would undertake indentity checks before transferring the call. If doctors had any doubts about the identity of a person or their parental responsibility for a child, they asked for further evidence to displayed in front of the camera.

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, however we did not see any examples of when this system had been used because the provider told us it had not experienced any serious incidents within the previous three years.

We were told learning from incidents would be discussed with clinical staff during regular clinical meetings and with other staff during team meetings at the headquarters.

Not sufficient evidence to rate

Are services effective?

We were not able to rate Effective because we did not have enough evidence to conclude whether people's care, treatment and support achieved good outcomes, promoted a good quality of life and was based on the best available evidence.

Assessment and treatment

At the time of this inspection, the service did not provide diagnoses and did not prescribe medicine or treatment. We were told telephone consultations lasted up to 20 minutes at which time the call ended automatically. The provider told us clinicians were advised to make notes during calls, but this was not a mandatory requirement and the service did not have a process in place to record or store these notes and relied on doctor's professional integrity to ensure notes were stored properly or destroyed in an appropriate manner.

Because the provider had previously undertaken video consultations, we reviewed five examples of written medical records from such consultations and found these 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.

Doctors 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 clinician considered that a caller needed further examination, they were advised to arrange a face to face consultation with a medical professional.

All calls to the pay-per-use telephone advice service were recorded and stored in digital format on the service's secure server system. The service audited approximately five percent of calls each month and had a process in place to provide feedback to clinicians.

Quality improvement

We were told the clinical director listened to recordings of a sample of calls for every doctor monthly and reviewed the quality of the advice provided and we saw evidence showing the clinical director provided feedback to doctors during clinical meetings and one to one meetings. We also saw records of historical prescribing audits of antibiotic prescribing and noted these had also been discussed. However, there was limited evidence the service collected and monitored information about how the telephone advice service impacted on patients' outcomes beyond the auditing of telephone calls and previously, antibiotic prescribing.

Staff training

All staff completed induction training which varied according to their role within the service. Mandatory training for all staff included: Safeguarding for vulnerable adults and children; information governance, GDPR and health and safety. There was a training matrix, overseen by a named member of non-clinical staff, which identified when training was due.

Doctors registered with the service received specific induction training prior to treating patients. An induction log was held in each staff file and signed off when completed. They also had access to supporting material, for example, a clinical handbook, how the IT system worked and aims of the consultation process. Staff we spoke with told us they received excellent support if there were any technical issues and could access policies. When updates were made to the IT systems, doctors received further online training.

Potential clinical candidates had to be registered with the General Medical Council (GMC) and were on the national performer's list. Doctors meeting the specifications of the service then had to provide documents including: their medical indemnity insurance, proof of registration with the GMC (and other relevant professional bodies), proof of their qualifications, and certificates for training in safeguarding. The service conducted checks with the Disclosure and Barring Service (DBS) prior to employment.

Coordinating patient care and information sharing

At the time of this inspection, the service did not offer diagnoses, prescribe medicine or treatment and did not refer patients to other providers. People using the telephone advice line were not required to verify their identity or telephone number. Doctors advised callers the service was not designed as a replacement for face to face consultations with a medical professional and would advise callers with specific concerns to visit their registered GP or contact the emergency services when appropriate.

Not sufficient evidence to rate

Are services effective?

When the provider had undertaken video consultations previously, patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service. Where a patient refused to agree to information sharing with their NHS GP the doctor had the option to withhold prescribing, except where prescribing was in the clinical interests of the patient.

Supporting patients to live healthier lives

Doctors providing the telephone advice service who identified patients who may be in need of extra support were able to give advice about healthy lifestyles, for instance, smoking cessation, alcohol consumption, and sleep advice. The provider's website also included a library of written and video resources providing advice about common ailments as well as advice about managing general health.

Not sufficient evidence to rate

Are services caring?

We were not able to rate Caring because we did not have enough evidence to conclude whether the service involved and treated people with compassion, kindness, dignity and respect.

Compassion, dignity and respect

We were told that the doctors undertaking telephone consultations were instructed to do so in a private room and were not to be disturbed at any time during their working time. In addition, doctors were advised not to take calls whilst they were undertaking clinical sessions in other workplaces. This was to mitigate against the risk of being disturbed during a call.

The provider told us every telephone consultation was recorded and stored on a secure server. The clinical director reviewed a sample of calls for each doctor every month and assessed whether the clinician on the call had treated the caller with dignity and respect as well as the technical quality of the call. We listened to six of these calls during this inspection and found callers were treated respectfully and with dignity.

We did not speak to patients directly on the days of the inspection. Prior to the inspection we asked the service to advise patients of the forthcoming inspection and that they could provide comments about the service to CQC. However, the provider had moved address shortly before the inspection was announced and had not received the notice of inspection or the information about requesting patient feedback.

Involvement in decisions about care and treatment

Patients accessing the telephone advice line were not provided with a diagnosis or prognosis, were not offered any treatment and could not be prescribed any medicine. However, doctors were able to provide additional information about diagnoses already received, provide information about treatment or medicine a caller had been prescribed elsewhere as well as giving advice about health-related matters. We were also told doctors could providing callers with a range of possible causes of particular conditions which could be discussed with a medical professional in a face to face consultation. Clinicians were advised to use a stopwatch to help them manage the structure of the consultation, in particular to advise callers when the call was coming towards the end of the consultation time. For instance, we were told doctors would advise callers where there were three minutes of call time remaining. Doctors were not able to extend the time of the call.

Good

Are services responsive to people's needs?

We rated responsive as Good because the provider had ensured people using the service were aware of the limitations of the service provided and encouraged people with urgent needs or specific concerns to visit a medical professional for a face to face consultation or to contact the emergency services if their needs were urgent.

Responding to and meeting patients' needs

At the time of this inspection, the only service provided within scope of CQC regulation was a telephone advice line. Patients accessing the telephone advice line could do so twenty-four hours per day. People who had used the service previously could request an appointment with a specific doctor by inputting the unique PIN number of the doctor.

The 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 or NHS 111.

The nature of the service meant people could contact the service from abroad, however all medical practitioners were required to be qualified to work within the UK and registered with the GMC.

The provider made clear to patients what the limitations of the service were and had provided guidance to doctors to recognise the signs of, for example, potential premium telephone rate service addiction. People exhibiting these signs were encouraged to desist and were provided with contact details for a support organisation who could offer help and advice with this.

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.

Doctors providing the telephone advice service followed a scripted introductory conversation during which they would introduce themselves and describe their qualifications.

Managing complaints

Information about how to make a complaint was available on the service's website. The service had developed a complaints policy and procedure. The policy contained appropriate timescales for dealing with complaints. There was escalation guidance within the policy, and there was a specific form for recording complaints. We reviewed the complaints system and noted that comments and complaints made to the service were recorded. We reviewed three complaints received in the past 12 months.

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

Consent to care and treatment

There was clear information on the service's website explaining 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 make contact with any enquiries.

The service sought assurance all doctors 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. Although the service did not currently provide services to people aged under eighteen years, when it had previously provided care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the doctor assessed the patient's capacity and, recorded the outcome of the assessment.

Requires improvement

Are services well-led?

We rated well-led as Requires improvement because there were weaknesses in governance systems. In particular, the provider did not ensure clinicians made written notes of calls to the telephone advice service and did not have a process in place to manage any notes that were produced. In addition, it did not have effective arrangements in place to oversee the secure storage of recordings of calls made to the service.

Business Strategy and Governance arrangements

The provider told us it had recently restructured the organisation which involved relocating to different premises, but it had not applied to register the new location. During the inspection, we discussed this with the provider and were told the recent restructure had taken place at very short notice and as a result of an unexpected change in circumstances. The provider told us this had resulted in the requirement to notify CQC being overlooked. We were told this would be rectified.

At the time of this inspection, the provider was in the process of writing a new business strategy. We were told all video consultations had ceased until the revised strategy and underpinning resources were in place to ensure this could be delivered safely and to a high standard but at the time of this inspection, the provider had not identified a date when the service would be resumed.

As a result of the recent changes, there was a new organisational structure in place and all non-clinical staff had taken on additional responsibilities. Staff we spoke with were aware of their roles and were confident with their new responsibilities. There was a range of service specific policies which were available to all staff. These were reviewed annually and updated when necessary.

All calls to the telephone advice line were recorded. The provider recommended doctors made handwritten notes during calls, but it had not made this a requirement. Although doctors were provided with guidance around keeping notes confidential there were no arrangements to collect, store or destroy any notes that were made. The provider told us this was because the service was for medical advice only and doctors did not record personal information about callers and did not offer diagnoses, prescribe medicine or treatment and did not make referrals to other providers.

Consultation notes were maintained for appointments undertaken with employees or members of other organisations with whom the service had contracts in place. We were able to review historical consultation notes from a number of video consultations and found these were accurate, and securely kept. However, we were unable to see consultation notes for the majority of previous video consultations because ownership of these records had been retained by a former client.

Leadership, values and culture

The Clinical Director had responsibility for any medical issues arising. They attended the service daily. There were systems in place to address any absence of this clinician within the clinical management team.

The values of the service were: patient centred, innovation, unity, excellence and integrity.

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

The provider did not hold information about people who used the pay-per-call telephone advice service. This was because it did not require people using the service to verify identity or contact details and did not store this information if a person chose to disclose it. All calls to the service were recorded but we found the provider did not have a clear policy in place about how these recordings should be stored or a process to audit access to recordings. We were told any access to the system would produce an audit trail which could be reviewed if any unauthorised access was suspected.

Details of callers contacting the service under arrangements made by employers or insurance arrangements were recorded and we saw there were systems in place to protect the storage and use of all patient information. The provider 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

Requires improvement

Are services well-led?

At the time of this inspection, there was no process in place to collect feedback about the pay-per-call telephone advice service. However, we were told the clinical director reviewed a sample of recordings each month and used this as an opportunity to assess the quality of the service provided by doctors. The provider had arrangements in place with corporate clients to review its services and used these arrangements to identify areas where services could be improved. We saw evidence regular meetings with corporate clients including one set of minutes in which the service put forward a suggestion about improving the process of verifying patient identify using a technological solution.

We were told people who had used the video consultation service had been able to leave a rating based on a five-star rating system. However, we did not see any examples of when this had been used.

There was a process in place for doctors to provide feedback about the technical quality of the operating system and could contact the clinical director at any time to discuss concerns or seek advice and we saw notes from meetings where aspects of calls, including sound quality and ease of connection had been discussed.

The provider had a whistleblowing policy in place. A whistle blower is someone who can raise concerns about practice or staff within the organisation.

Continuous Improvement

At the time of this inspection, the provider had recently undertaken a significant restructure and had limited the range of services provided. The provider described plans to make improvements to services, but these were still at the development stage and evidence of progress was limited. For instance, we were told of a new technical process to improve how the identity of people accessing video consultations would be confirmed if and when this service was resumed.

Formal meetings were held monthly, however the team worked in an open plan office and staff told us there was a culture of openness in which they felt they could raise concerns and discuss areas of improvement at any time.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely. Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: There was a lack of systems and processes established and operated effectively to ensure compliance with requirements to demonstrate good governance. In particular we found: •The provider did not ensure doctors made or stored written notes of calls to the telephone advice service and did not have a process in place to manage any notes that were produced. •The provider did not have an effective process in place to assess or improve the quality of the service provided. •The provider did not have effective arrangements in place to oversee the secure storage of recordings of calls made to the service. This was in breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.