Doctor Now Limited

Doctor Now

Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 19 January 2016 to ask the service the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

Background

Doctor Now is an independent GP service offering a range of general medical and specialist services including an out of hours service. Services provided include GP and nurse led consultations, health screening and pathology services. The service is an accredited MASTA travel clinic and yellow fever centre.

Services are provided between 8am and 8pm from Monday to Friday and from 9am to 4pm on Saturdays. Patients who hold relevant membership with Doctor Now are able to access services and care from a GP 24 hours a day. Other membership options provide patients with monthly home visit monitoring by a nurse and regular GP home visits throughout the year.

Services are provided by 11 GPs and three practice nurses. Three of the GPs are directors of the service and eight GPs work on a sessional basis. GPs and nurses are supported by a practice manager, an assistant practice manager and a team of reception, administration and support staff.

The Chief Medical Officer and Managing Director of Doctor Now is the registered manager. A registered manager is a person who is registered with the Care Quality Commission (CQC) to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection and we spoke to some patients on the day of our inspection. 20 patients provided feedback about the service. All of the comments were positive about the care they had received. Patients told us that staff acted in a professional manner and they felt they received good standards of care.

Our key findings were:

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients and staff were not always assessed and well managed. The service had not undertaken regular fire drills. Risk of exposure to legionella bacteria had not been assessed.
- There was a lack of formal arrangements to ensure infection control processes were fully implemented.
- There was a lack of systems and processes to ensure patients were protected from abuse.
- Travel vaccination services were well managed but medicines were not always stored securely.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- Staff had not always received training appropriate to their roles and further training needs had not always been identified and planned.
- Staff had not received regular supervision and appraisal of their performance.
- The practice worked closely with other organisations and with local community services in planning how care was provided to ensure that they met patients' needs.
- There was a lack of systems in place for completing clinical audit cycles. The service was unable to demonstrate that audits were driving improvement in performance to improve patient outcomes.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Feedback from patients about their care was consistently and strongly positive.
- The service offered highly flexible opening hours and access to appointments which met the needs of their patients.
- Information about services and how to complain was available and easy to understand.
- The provider was aware of, and complied with, the requirements of the Duty of Candour.

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

- Ensure all health and safety risk assessments are completed and action is taken as needed including for legionella bacteria and fire drills.
- Implement procedures to ensure medicines are stored securely at all times.
- Ensure effective systems for responding to identified fluctuations in medicines fridge temperatures.
- Ensure systems and processes are in place to protect patients from the risk of abuse, including the development of clear written policies and procedures and training in the safeguarding of children and vulnerable adults at an appropriate level for all staff.
- Ensure infection control processes are in place, including regular auditing and the safe management of sharps disposal.
- Ensure all staff receive regular supervision and appraisal as well as training for their role, including training in chaperoning, health and safety, fire safety, information governance, the Mental Capacity Act 2005 and infection control.
- Ensure clinical audits are used to promote continuous improvement.
- Review written policies and procedures to ensure their accuracy and currency.

There were areas where the provider could make improvements and should:

- Ensure regular calibration of the spirometer in line with manufacturer's recommendations.
- Ensure the vaccination status of all appropriate staff is established and that staff receive booster immunisations where required.
- Ensure clear information is provided for staff and patients about chaperoning arrangements.
- Establish a business continuity plan to manage emergencies that may impact on the daily operation of the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this service was not providing safe care in accordance with the relevant regulations. We have told the provider to take action.

- Services were provided from modern, well equipped and well maintained premises.
- There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members.
- Staffing levels were appropriate for the provision of care and treatment with a good staff skill mix across the whole service.
- There was a lack of risk management processes to manage and prevent harm in some areas. There were no processes in place to ensure that fire drills were conducted. Risks associated with potential exposure to Legionella bacteria had not been assessed.
- There was a lack of formal arrangements to ensure infection control processes were fully implemented. There was a lack of auditing of infection control processes. Infection control policies and procedures did not reflect current guidance.
- There were robust processes in place to manage travel clinic services and associated risks. However, medicines management processes did not always ensure the safe storage of medicines.
- GPs had a good knowledge of safeguarding issues and had undertaken training in the safeguarding of adults appropriate to their role. However, GPs were trained to level 2 only in the safeguarding of children. Other staff within the service had not received up to date training in the safeguarding of children and vulnerable adults. The service's policies on safeguarding lacked clarity and detailed information to support staff.

Are services effective?

We found that this service was not providing effective care in accordance with the relevant regulations. We have told the provider to take action.

- Staff assessed needs and delivered care in line with current evidence based guidance.
- There was a lack of systems in place for completing clinical audit cycles. The practice was unable to demonstrate that audits were driving improvement in performance to improve patient outcomes.
- Staff had not always received training in key areas. For example, some staff had not received up to date training in fire safety, information governance, infection control, child and adult safeguarding and the Mental Capacity Act 2005. Where staff told us they had completed training in some areas, record keeping demonstrating training was poor.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. For example nurses had received up to date training to support patients with asthma and diabetes.
- Staff had not always had an annual appraisal or agreed a personal development plan.

Are services caring?

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

- Feedback from patients spoken with and through completed comment cards was highly positive about their experience of the service.

Summary of findings

- Patients told us they were listened to, treated with respect and were involved in the discussion about their treatment options which included any risks, benefits and costs.
- We observed staff to be caring and committed to their work. We found staff spoke with knowledge and enthusiasm about their work and the team approach within the service.
- Patients said staff displayed empathy, friendliness and professionalism towards them.

Are services responsive to people's needs?

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

- The service offered flexible opening hours over six days each week and appointments to meet the needs of their patients.
- A wide range of membership options were available to patients to meet their individual needs. For example, patients who held relevant membership with Doctor Now were able to access services and care from a GP 24 hours a day. Other membership options provided patients with monthly home visit monitoring by a nurse and regular GP home visits throughout the year.
- The service had made reasonable adjustments to accommodate patients with a disability or impaired mobility.
- The service handled complaints in an open and transparent way and apologised when things went wrong. The complaints procedure was readily available for patients to read in the reception area and on the service's website.
- The service proactively sought patients' feedback and engaged patients in the delivery of the service. Feedback was gathered through a patient panel and annual patient surveys. complaints received.
- Regular audits of patient service systems were undertaken such as appointment availability and telephone answering times.

Are services well-led?

We found that this service was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action.

- There was a management structure in place and staff understood their responsibilities. The registered manager was always approachable and the culture within the service was open and transparent.
- Staff were aware of the organisational ethos and philosophy and told us they felt well supported and could raise any concerns with the registered manager or practice manager.
- Regular staff meetings took place and these were recorded.
- There were some effective clinical governance systems in place. However there was a lack of clinical audit to support continuous improvement and learning.
- The service had not always assessed risks to patients and staff.
- Staff had not always received training appropriate to their roles and further training needs had not always been identified and planned.
- Staff had not received regular supervision and appraisal of their performance.
- The service proactively sought the views of staff and patients.
- The service had some policies and procedures in place to govern activity and these were available to staff. However many of the policies lacked content and clarity. Some of the policies did not reflect the procedures which staff followed within the service.

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Detailed findings

Background to this inspection

We inspected this service as part of our new comprehensive inspection programme 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 provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2015 and to look at the overall quality of the service.

We carried out an announced inspection visit on 19 January 2016 as part of the independent doctor consultation service inspection pilot.

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a CQC nursing advisor, a practice manager specialist advisor and a CQC observer.

Before visiting, we reviewed a range of information that we held about the service and asked other organisations to share what they knew. Prior to the inspection we reviewed the information provided in response to a pre-inspection information request to the provider.

During our visit we:

- Spoke with a range of staff including doctors, managers, a practice nurse and administration staff.
- Spoke with patients who used the service and observed how people were being cared for.
- Reviewed the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There was an effective system in place for reporting and recording significant events. Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. The service carried out a thorough analysis of the significant events and we saw evidence that they were discussed at fortnightly clinical meetings. Significant event discussions were a standing item on clinical meeting agendas.

We reviewed safety records, incident reports, national patient safety alerts and minutes of clinical meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, the service had developed a patient information leaflet about vaccine scheduling following a vaccine administration error.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

The provider was aware of and complied with the requirements of the Duty of Candour. The service encouraged a culture of openness and honesty. The service had systems in place for disseminating information about notifiable safety incidents.

Reliable safety systems and processes (including safeguarding)

The service had a named lead for the safeguarding of children and vulnerable adults. However, not all staff were aware of this. The service's policies on safeguarding lacked clarity and detailed information to support staff. For example, we reviewed the practice policy on safeguarding children and young adults and found there was no reference to staff training and no reference to the named lead within the service or who staff should escalate concerns to internally. The service policy on the protection of vulnerable adults was brief and made reference to out of date guidance. GPs within the service had a good knowledge of safeguarding issues and procedures. Other staff demonstrated they understood their responsibilities but had not always received training relevant to their role. Some staff told us they had received safeguarding training two years previously. However, no records of this training were available. Other staff told us that they had received no training in safeguarding during their employment with the service. We reviewed the training records of three administration staff who had undergone induction between January and March 2015 and records confirmed they had not received training. We found the doctors within the service were trained to level 2 only for safeguarding children.

Staff told us that patients were able to request a chaperone if required, however arrangements were not clearly defined. The service's chaperone policy stated that it was expected that a chaperone would be in attendance except for head, neck and blood pressure examinations. However, notices within the service advised patients to request a chaperone if one was required. Staff told us that administration staff or nurses would act as a chaperone if required. However, there were no records to confirm that those staff members had undertaken training to support the role.

We found the electronic patient record system was only accessible to staff with delegated authority which protected patient confidentiality. There were systems in place to back up patients records securely and a named lead for information governance and information technology systems.

Medical emergencies

The service had adequate arrangements in place to respond to emergencies and major incidents. There was a push button alarm in the reception area which alerted staff to any emergency. All staff received annual basic life support training. Emergency medicines and equipment were easily accessible to staff in a secure area of the service and all staff knew of their location.

The service had suitable emergency resuscitation equipment in accordance with guidance issued by the Resuscitation Council UK. This included an automatic external defibrillator (AED). (An AED is a portable electronic device that analyses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm) and oxygen with face masks for both adults and children. The service also had medicines for use in an emergency in accordance with guidance from

Are services safe?

the British National Formulary. Records completed showed regular checks were carried out to ensure the equipment and emergency medicines were safe to use. Records showed staff had completed training in emergency resuscitation and basic life support. Further training was booked for February 2016. Staff we spoke with demonstrated they knew how to respond if a patient suddenly became unwell.

The service also had trained first aiders with first aid kits and an accident book available on site.

Staffing

We reviewed five personnel files and found that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, medical indemnity cover, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patient's needs.

The service had recently recruited additional staff to support increasing patient numbers accessing services.

Monitoring health & safety and responding to risks

There were some procedures in place for monitoring and managing risks to patient and staff safety. All of the staff team undertook some basic internal health and safety awareness training as part of their induction. However, we examined training records and found that staff had not received updated training in health and safety and fire safety. Some staff members had further delegated responsibilities for implementing health and safety at work. For example, the practice manager was the appointed fire marshal. Fire safety equipment, such as fire extinguishers, had been regularly maintained. Following our inspection the service submitted evidence to confirm that they had carried out a fire risk assessment of the premises in 2014. There were processes in place to ensure fire alarms were regularly tested but staff told us that fire drills were not regularly carried out.

There were effective arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. We looked at the COSHH file and found risks (to patients, staff and visitors) associated with substances hazardous to health had been identified and actions taken to minimise them.

The practice manager told us there was no formal business continuity plan in place to deal with a range of emergencies that may impact on the daily operation of the service. Managers were able to access service records remotely if required and facilities were in place to enable telephones to be diverted to specified mobile numbers. Some doctors had practising privileges in nearby independent hospitals where services could be transferred.

Infection control

The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. However, there was a lack of formal arrangements to ensure infection control processes were fully implemented. Staff, including nurses, were unclear who the named lead for infection control was within the service and there was a lack of auditing of infection control processes.

We reviewed infection control policies and procedures and found that they did not reflect or make reference to current codes of practice and lacked information around some areas of infection prevention. For example there was no guidance in the policies about the handling of spillages or staff vaccination requirements and access to occupational health support.

Staff had not received up to date training in infection control processes. Staff employed recently by the service told us they had not received training as part of their induction process. Reception staff told us they believed it was their responsibility to clear up spillages, for example of bodily fluids, which occurred in the waiting area but had not received training to do so. They were unaware of the equipment available to them but said they would look in the cleaning cupboard to access appropriate equipment.

We noted that the service held records to confirm the hepatitis B status of GPs and nurses working within the service but had not monitored their immunity to chicken pox and measles.

Environmental and equipment cleaning schedules were in place for all areas of the service. Hand wash solution, hand

sanitizer and paper towels were available in each room. There were good supplies of protective equipment for patients and staff members. Disposable curtains were in use in clinical rooms.

The service had an on-going contract with a clinical waste contractor. We saw the differing types of waste were appropriately segregated and stored at the centre whilst awaiting collection. This included clinical waste and the disposal of sharps. However, staff were not always following the appropriate guidance on the safe disposal of sharps waste. We found sharps bins were not being used according to the current regulations for the disposal of such waste. We noted that one sharps bin had been in use for a period of seven months. The service did not hold a supply of purple lidded sharps bins to support the safe disposal of items contaminated with medicines containing hormones.

The service had not assessed the risks associated with potential exposure to legionella bacteria which is found in some water systems. There were no processes in place to ensure regular checks were carried out to reduce the risk of exposure of legionella bacteria to staff and patients.

Premises and equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We saw evidence that testing of electrical items and calibration of relevant equipment had been carried out in July 2015. For example, digital blood pressure machines and weighing scales. However, we found that there were no regular verification checks of the spirometer which was used to check patients' lung function. The service's policy indicated that such calibration should be carried out using a calibration syringe before each session and after every 10 patients. However, staff were unaware of this policy or process and there was therefore a lack of quality assurance for the use of the spirometer and patients' spirometry results. Following our inspection the service reviewed guidance from the manufacturer of the spirometer and confirmed the need for regular calibration checks.

We found that the service had a supply of liquid nitrogen which nurses used to treat warts and other minor skin conditions. The liquid nitrogen was stored appropriately within a locked, labelled cupboard and personal protective equipment such as gloves and goggles, were available to staff to ensure its safe use.

Safe and effective use of medicines

We reviewed the arrangements and systems in place for managing medicines, including emergency medicines and vaccines within the service (including obtaining, prescribing, recording, handling, storing and security). The practice implemented a protocol for repeat prescribing which was in line with national guidance. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. Reviews were undertaken for patients on repeat medicines. All prescriptions were reviewed and signed by a GP before they were given to the patient. Prescription pads were securely stored and there were systems in place to monitor their use. The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of these directions.

We checked medicines stored in treatment rooms and medicine refrigerators and found they were not always stored securely and were not always only accessible to authorised staff. The service had two vaccine fridges which were located immediately outside of the nurses' treatment room in a corridor area which was also accessed by patients. We noted during the day of our inspection that keys were left in the locks of the fridges at times when there were no staff present.

There was a policy and process for ensuring that medicines were kept at the required temperatures. Records showed that fridge temperature checks were carried out daily. However, we found that temperatures had been recorded which exceeded the recommended range on several dates within January 2016. The service did not have effective systems for responding to such fluctuations. No action had been taken to investigate the reasons for the increases in temperature or to assess the associated risks to patient safety.

Processes were in place to check medicines were within their expiry date and suitable for use. This included

Are services safe?

recorded checks of stock and expiry dates. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The service was an accredited MASTA (Medical Advisory Service for Travelers Abroad) travel clinic and yellow fever centre. We found that nurses involved in providing travel vaccinations and other immunisations had undertaken initial training and had attended regular updated training. The service utilised specific software via a MASTA 'e-platform' to support the management and recording of their MASTA services. Advice provided to patients, such as malaria prevention advice, and details of vaccinations and medicines administered were recorded on the e-platform. Details were also recorded within the service's electronic patient record system. The e-platform enabled staff to conduct a detailed risk assessment relating to each individual patient prior to administration of the vaccine or medicine. This included their previous medical history, the travel destination, reason for travel, activities likely to be undertaken and the length of the trip. Patients were provided with a written record of their vaccinations and the advice given following treatment.

The service was also a registered yellow fever vaccination centre. They complied with reporting requirements to The National Travel Health Network and Centre (NaTHNaC) in submitting an annual return detailing vaccinations given. Staff who administered yellow fever vaccinations had received regular updated training. Staff had a good understanding of systems for reporting suspected serious adverse events via the Medicines and Healthcare Products Regulatory Agency (MHRA) following yellow fever and other vaccinations.

Are services effective?

(for example, treatment is effective)

Our findings

Assessment and treatment

The service assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Staff were provided with regular updates directly from MASTA in relation to current vaccine schedules and information provided from the Foreign and Commonwealth Office about disease outbreaks and other local issues affecting countries worldwide.

We examined patient records and found that patients' needs were assessed and care was planned using templates on the service's electronic patient record system. Where the service was sharing the review and care of patients with long term conditions such as asthma or diabetes, with an NHS GP or a specialist, there were systems in place to ensure that assessment and treatment records were shared in a timely manner.

Staff told us that when there was a death of a patient or a patient received a significant diagnosis such as a diagnosis of cancer, there was a case review discussion within a clinical meeting held within the service. This enabled the service to review patient treatment outcomes and to determine learning points which may have arisen from the management of a patient's care. We saw evidence of minutes of those meetings which confirmed this.

The service was able to provide only very limited evidence of clinical audits which had been completed and which demonstrated quality improvement. We found that two individual doctors had carried out audits of their own practice relating to joint injections and hormone replacement therapy. However the outcomes of these audits had not been reviewed by the service team to determine whether they could be used to implement changes across the service to improve patient treatment outcomes. The service regularly undertook audits of internal processes and procedures such as appointment availability and telephone response times.

The service provided a range of health screening services such as well man and well woman checks. Staff told us that blood testing was used to proactively screen for undiagnosed conditions such as diabetes. Lung function tests were used to identify respiratory conditions. The service also promoted health and well-being via an information screen within the waiting area and the provision of information leaflets on specific subjects such as prostate cancer. Three patients who had completed CQC comment cards prior to our inspection told us how doctors had implemented prompt investigation and accurate diagnosis of their condition following prolonged delays whilst in the care of other primary care services.

Staff training and experience

The practice had a basic induction programme and checklist for newly appointed members of staff which covered internal processes regarding fire safety, products and services available to patients and confidentiality, as well as role specific duties and competencies.

We reviewed staff training records and found that staff were not up to date with training in key areas and other staff training records were incomplete. For example, staff had not received up to date training in fire safety, information governance, infection control, child and adult safeguarding, chaperoning and the Mental Capacity Act 2005. We reviewed the training records of 17 administration staff and found that none of those staff had received regular training in those key areas. Seven of those staff had been recruited to the service within the last 12 months but had not received training in those key areas. Where staff told us they had previously completed training in some areas, there was a lack of training records to confirm this.

The service was able to demonstrate how they ensured role-specific training and updating for relevant staff, for example for nurses involved in reviewing patients with long-term conditions, administering vaccinations and taking samples for the cervical screening programme. Nurses told us that the service was supportive of ongoing training and continuous professional development. Nurses had received initial high level training and ongoing updated training to support the management of patients with, for example, diabetes. Nurses told us that the service subscribed to nurse journals and they were able to attend regular educational sessions which included input from guest speakers.

There were some systems for identifying the learning needs of staff through a system of meetings and reviews of practice development needs. However, we found that most staff had not had an appraisal within the last 2 years. We noted that the practice manager and registered manager

Are services effective?

(for example, treatment is effective)

were aware of the need to re-establish a system of regular appraisal of staff. All GPs were up to date with their yearly continuing professional development requirements and all had been revalidated or had a date for revalidation. We saw that the practice held records to confirm this.

Working with other services

The information needed to plan for the delivery of services was available to relevant staff through the service's patient record system and the service intranet system. This included clinician's assessments and records, and investigation and test results. The service shared relevant information with the patient's permission with other services, for example, when referring patients to other services or informing the patient's NHS GP of any matters. Staff told us that over 20% of patients who attended the service had been referred directly by their NHS GP.

Staff worked with other health care professionals to meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred to, or after they were discharged from hospital. Nurses told us they referred patients to other services such as community nurses for wound care or to a local dermatology clinic.

Consent to care and treatment

We found staff sought patients consent to care and treatment in line with legislation and guidance. GPs understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. However, staff such as nurses had not received training in the Mental Capacity Act 2005 and some had a lack of understanding of best interest decisions. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance (Gillick). We saw the service obtained written consent before undertaking procedures. Information about fees was transparent and available within the service and on the website. The process for seeking consent was demonstrated through records and showed the service met its responsibilities within legislation and followed relevant national guidance.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We observed members of staff were courteous and very helpful to patients and treated patients with dignity and respect. Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Consultation room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

We observed patients were dealt with in a kind and compassionate manner. We observed staff being polite, welcoming, professional and sensitive to the different needs of patients. Staff we spoke with were aware of the importance of protecting patient confidentiality and reassurance. They told us they could access an empty room away from the reception area if patients wished to discuss something with them in private or if they were anxious about anything.

Staff explained to us how they ensured information about patients using the service was kept confidential. The service had electronic records for all patients which were held securely. The day to day operation of the service used computerised systems and the service had an external backup for this system. Staff members demonstrated to us their knowledge of data protection and how to maintain confidentiality.

Involvement in decisions about care and treatment

Staff told us patient's medical status was discussed with them in respect of decisions about the care and treatment they received. We saw these discussions were always documented.

The comments from patients indicated they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision.

Patients completed CQC comment cards to tell us what they thought about the service. We also spoke to some patients on the day of our inspection. 20 patients provided feedback about the service. All of the comments were positive about the service experienced. Patients said they felt the service offered an excellent service and staff were efficient, helpful, caring and knowledgeable. They said staff treated them with dignity and respect. All told us they were highly satisfied with the care provided by the service. The service had completed their own annual patient surveys and worked closely with a patient panel to support service improvements.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The service offered flexible opening hours and appointments to meet the needs of their patients. The range of services was kept under review to meet demand. Staff reported the service scheduled enough time to assess and undertake patients' care and treatment needs. Staff told us they did not feel under pressure to complete procedures and always had enough time available to prepare for each patient.

Staff and patients we spoke with told us that repeat prescription requests were usually processed on the same day.

The facilities provided by the service were comfortable and welcoming for patients, with a manned reception area and waiting room for patients. The premises could be accessed via a ramp and a manual door into the waiting area. The treatment and consultation areas were well designed and well equipped.

Tackling inequity and promoting equality

The service was offered on a fee basis only and was accessible to people who chose to use it.

We asked staff to explain how they communicated with patients who had different communication needs such as those who spoke another language. Staff told us they treated everybody equally and welcomed patients from different backgrounds, cultures and religions. Staff were able to access translation services if required.

Access to the service

Appointments were available to patients between 8am and 8pm Monday to Friday and from 9am to 4pm on Saturdays. Patients who held relevant membership with Doctor Now were able to access services and care from a GP 24 hours a day. Other membership options provided patients with monthly home visit monitoring by a nurse and regular GP home visits throughout the year.

The length of appointment was specific to the patient and their needs. Staff told us that the majority of appointments were scheduled for 30 minutes duration, with some 15 minute appointments scheduled where appropriate. Patients we spoke with and those who completed CQC comment cards prior to our inspection, reported excellent access to the service by telephone and to appointments. Patients told us they were usually seen on the same day. The service had recently monitored the time it took for staff to answer the telephone and told us that the slowest time recorded was 45 seconds. The service had identified a growth in demand for services and increasing patient numbers and planned to increase GP availability in order to ensure patients were provided with consistent access to services.

Concerns & complaints

There was a complaint policy which provided staff with information about handling formal and informal complaints from patients. Information for patients about how to make a complaint was available in the service waiting room and on the service website. This included contact details of other agencies to contact if a patient was not satisfied with the outcome of the service investigation into their complaint. The designated responsible person who handled all complaints was the practice manager.

We reviewed the complaint system and noted that all comments and complaints made to the service were recorded. We read the service procedure for acknowledging, recording, investigating and responding to complainants and found all of the six patient complaints which had been received over the past 12 months had received a response. We saw there was an effective system in place which ensured there was a clear response, with learning disseminated to staff about the event.

Are services well-led?

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

Our findings

Governance arrangements

The governance arrangements of the service were evidence based and developed through a process of continual learning. The registered manager and the practice manager had responsibility for the day to day running of the service. There was a clear leadership structure with named members of staff in lead roles. The service held regular meetings with the staff to discuss any issues and identify any actions needed. For example, clinical meetings were held within the service every two weeks. These meetings included the review of all reported safety incidents and review of patient treatment outcomes.

The service had a number of policies and procedures in place to govern activity and these were available to all staff. We reviewed a range of those policies and found that many of the policies lacked content and clarity. Some of the policies did not reflect the procedures which staff followed within the service and made reference to inaccurate processes. Some of the policies failed to make reference to relevant codes of practice, regulatory requirements and professional guidance resources.

Leadership, openness and transparency

The provider was aware of and complied with the requirements of the Duty of Candour. The organisation encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents.

When there was unexpected or unintended safety incidents the service gave affected patients reasonable support, truthful information and a verbal and written apology. They kept written records of verbal interactions as well as written correspondence.

We found the service held regular team meetings. All staff told us there was an open culture within the service and they had the opportunity to raise any issues at team meetings. Staff were involved in discussions about how to run and develop the service, and to identify opportunities to improve the service. For example, nurses told us they were able to attend clinical meetings within the service which were held on a fortnightly basis. We saw minutes of all meetings were recorded and circulated to staff. Meetings were well attended and well supported by doctors despite many of them working on a limited sessional basis within the service. The service held whole practice team meetings on a bi-monthly basis to which all staff members were encouraged to attend. Staff told us they felt well supported by management.

The registered manager told us that they aimed to continually share the future vision of the organisation with the staff team. The management team had held an away day in August 2015 in order to plan the strategy for the organisation in a way in which they felt staff could relate to. We saw evidence of the clear strategic objectives which had been defined within that meeting and how that information had been shared with team members.

Learning and improvement

Staff told us the service supported them to maintain their clinical professional development through training and mentoring. Nurses and GPs attended monthly educational sessions which provided the opportunity for joint learning. Staff told us that guest speakers were regularly invited to those sessions.

However, we reviewed staff training records and found that staff were not up to date with training in key areas and other staff training records were incomplete. We found that most staff had not had an appraisal within the last 2 years. We noted that the practice manager and registered manager were aware of the need to re-establish a system of regular appraisal of staff.

There was a lack of clinical auditing within the service to ensure the regular monitoring of the quality of care and treatment provided and the implementation of changes to improve patient treatment outcomes.

Provider seeks and acts on feedback from its patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service. It had gathered feedback from patients through its patient panel and through surveys and complaints received. The patient panel were encouraged to work with the practice to provide their views on the services provided and to support service improvements.

The service conducted an annual patient survey and we saw that the last survey had been carried out in December 2014. A summary of patient feedback and comments had

Are services well-led?

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

been collated and where appropriate, individual comments had been followed up and responded to directly with the patient. Findings of the survey had been reviewed within a meeting held with the patient panel in March 2015. We noted that 100% of patients who responded said they would recommend Doctor Now to a friend or family member. 97% of respondents were satisfied with the level of care they received from the service.

All staff were involved in discussions about how to run and develop the practice within regular practice meetings, and managers encouraged all members of staff to identify opportunities to improve the service delivered. Staff told us they were given the opportunity to raise items for the agenda prior to team meetings.

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

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **We found that the registered provider had not assessed the risks to the health and safety of service users of receiving care and treatment and had not done all that is reasonably practicable to mitigate any such risks.** **We found that the registered provider had not ensured the proper and safe management of medicines.** **We found that the registered provider had not ensured that effective systems were in place to assess the risk of, and prevent, detect and control the spread of infections, including those that are healthcare associated.** **This was in breach of regulation 12 (1) (2) (a) (b) (g) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **We found that the registered provider had not ensured that systems and processes were established and operated effectively to prevent abuse of service users.** **This was in breach of regulation 13 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

We found that the registered provider had not always assessed, monitored and improved the quality and safety of services provided.

We found that the registered provider had not always maintained records which are necessary to be kept in relation to the management of the regulated activity.

We found that the registered provider had not always evaluated and improved their practice in respect of the processing of the information referred to above.

This was in breach of regulation 17 (1) (2) (a) (b) (d) (ii) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found that the registered provider had not always ensured that staff received appropriate training, including in chaperoning, health and safety, fire safety, information governance, the Mental Capacity Act 2005 and infection control. We found that the registered provider had not always ensured that staff received supervision and appraisal as necessary to enable them to carry out the duties they were employed to perform. This was in breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.