

# Babylon Healthcare Services Ltd

## Inspection report

60 Sloane Avenue

London

SW3 3DD

Tel: 0207 1000 762

[www.babylonhealth.com](http://www.babylonhealth.com)

Date of inspection visit: 07 Feb to 07 Feb 2019

Date of publication: 21/05/2019

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.

# Overall summary

Letter from the Chief Inspector of General Practice

We previously inspected location name on 4 July 2017. The full comprehensive report on inspection can be found by selecting the 'all services' link for location name on our website at .

At our previous inspection on 4 July 2017 we found that in some areas the service was not providing safe and effective care. We issued a requirement notice in relation to Regulation 12, Safe Care and Treatment.

We carried out an announced comprehensive inspection at Babylon Healthcare Services Ltd on 7 February 2019 to follow up on the breach of regulation identified during the previous inspection. At this inspection, we found the provider had addressed the issues identified at the last inspection.

Babylon Healthcare Service Ltd provides an online GP consultation service. They employ GPs on the General Medical Council (GMC) GP register to work remotely and undertake patient consultations. Patients are able to book a ten minute consultation with a GP, 24/7, 365 days a year. Consultations are undertaken through video call or phone call. Subscribers to the GP consultation service can pay a monthly fee or pay for each consultation.

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

Are services safe?

We found the service was providing a safe service in accordance with the relevant regulations.

Are services effective?

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

Are services caring?

We found the service was providing a caring service in accordance with the relevant regulations.

Are services responsive?

We found the service was providing a responsive service in accordance with the relevant regulations.

Are services well-led?

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

## **The areas where the provider should make improvements are:**

- Implement a system for identifying the location of each patient at the time of their consultation, in order that help can be sent to them in an emergency.
- Improve the written information supplied to patients who are prescribed medicines for unlicensed indications.
- Continue to review the management of clinical risk in video consultations.
- Develop quality improvement activities to improve outcomes in the quality of care patients receive.
- Continue to review and implement the policy relating to the clinical circumstances where information should be shared with the NHS GP especially in relation to the treatment of long-term conditions.
- Improve the arrangements for patients wishing to book an appointment with a GP of a specific gender.
- Improve the whistleblowing policy to ensure it includes external organisations for reporting concerns.

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

## Our inspection team

The inspection team consisted of a Lead Inspector, second Inspector, two GP Specialist Advisors, a Practice Manager Specialist Advisor and a member of CQC's Medicines Team.

## Background to Babylon Healthcare Services Ltd

### Background

Babylon Healthcare Service Ltd provides an online GP consultation service, which patients can access online or via a digital application (app).

Patients can either pay for single consultations or subscribe to the service for a fixed period, during which they have unlimited access.

Patients book a consultation online or via the app, and select the date and time of their consultation. At the time of their appointment, the GP contacts the patient and the consultation is held as a video chat.

Where appropriate, the GP can issue a prescription to the patient which is sent either to the pharmacy of their choice or to a pharmacy delivery service.

The service employs GPs on the General Medical Council (GMC) GP register to work remotely and undertake patient consultations. Patients are able to book a ten minute consultation with a GP 24/7, 365 days a year.

### How we inspected this service

Before the inspection we gathered and reviewed a wide range of information including information requested from the provider and information shared with us by people who had used the service. During this inspection we spoke to the Managing Director, Chief Medical Officer, Medical Director, Governance Director, Operations Director, GPs working for the service, and members of the management and administration team. In addition, we;

- Interviewed by telephone a randomised sample of GPs who worked remotely.
- Reviewed 49 personal care or treatment records.
- Reviewed in detail, complaints and concerns received by the provider and information of concern shared directly with the Care Quality Commission by people who had used the service.

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

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

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

### Why we inspected this service

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to follow-up on breaches of regulations identified during the previous inspection in July 2017.

# Are services safe?

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

## **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 including the contact details of local authorities' dependant on where the patient resided. All the GPs had received adult and level three child safeguarding training. It was a requirement for the GPs registering with the service to provide evidence of up to date safeguarding training certification.

The service did treat children when accompanied by their parent or guardian. Consultations with children would only take place where consent had been given for details of the consultation to be shared with the child's registered GP.

## **Monitoring health & safety and responding to risks**

The provider headquarters was located within modern offices where the IT system and a range of administration staff were based. Patients were not treated on the premises as GPs carried out the online consultations remotely; usually from their home. All staff based in the premises had received training in health and safety including fire safety.

The provider expected that all GPs would conduct consultations in private and maintain the patient's confidentiality. Each GP used an encrypted, password secure laptop to log into the operating system, which was a secure programme. GPs were required to complete a home working risk assessment to ensure their working environment was safe and appropriate for them to provide video consultations in.

There were processes in place for managing test results and referrals. The service was not intended for use by patients with either long-term conditions or as an emergency service. In the event an emergency did occur, the provider did not have a system in place to ensure the location of the patient at the beginning of the consultation was known, so emergency services could be called.

GPs were able to flag patient records where they had specific concerns about a patient. Patients with identified risks were discussed in clinical meetings.

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.

The provider had systems to monitor clinical risk in video consultations for example by reviewing random consultations as part of peer review. However, they were not selecting more difficult areas of clinical risk to focus on. This meant more difficult areas of clinical risk could be missed such as the management of chest infection or abdominal pain.

## **Staffing and Recruitment**

There were enough staff, including GPs, to meet the demands for the service and there was a rota for the GPs. There was a support team available to the GPs during consultations and a separate IT team. The majority of prescribing doctors were permanently employed by the service; the service employed some locum GPs, who were paid on a sessional basis.

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

Potential GP employees had to be registered with the General Medical Council (GMC) and on the GP register. They also had to provide an up to date appraisal and certificates relating to their qualification and training in safeguarding and the Mental Capacity Act.

Newly recruited GPs were supported during their induction period and an induction plan was in place to ensure all processes had been covered. GPs completed test scenario consultations as part of the recruitment process and, as part of their induction, their consultations would be reviewed and monitored.

We reviewed a selection of recruitment files which showed that the necessary documentation was available. The provider kept records for all staff including the GPs and there was a system in place that flagged up when any documentation was due for renewal such as their professional registration.

# Are services safe?

## Prescribing safety

All medicines prescribed to patients during a consultation were monitored by the provider to ensure prescribing was evidence based. If a medicine was deemed necessary following a consultation, the GPs were able to issue a private prescription to patients. The provider had risk-assessed the treatments on offer, taking into account the digital consultation medium. GPs were encouraged to prescribe from a set formulary which did not include controlled drugs, high risk medicines, or medicines liable to abuse or misuse. If a GP deviated from the set formulary, the prescription was automatically referred to a senior clinician to review the prescribing decision. The senior clinician could then approve or reject the non-formulary prescription.

The service encouraged good antimicrobial stewardship by only prescribing from a limited list of antibiotics which was based on national guidance. The provider audited antimicrobial use for some specific conditions to check whether GPs were prescribing in accordance with national guidance. We saw evidence of GPs issuing delayed prescriptions for antibiotics to reduce inappropriate use.

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

Prescriptions were sent electronically to the patient's chosen pharmacy. Patients could also choose for the prescribed medicines to be dispensed and delivered to them via the service's contracted pharmacy delivery service.

The service prescribed some medicines for unlicensed indications, for example for the treatment of altitude sickness. (Medicines are given licences after trials have shown they are safe and effective for treating a particular condition. Use of a medicine for a different medical condition that is not listed on their licence is called unlicensed use and is higher risk because less information is available about the benefits and potential risks.) GPs gave patients clear information during their consultation to explain when medicines were being used outside of their licence, and written information was supplied to patients about prescribing medicines for unlicensed use. However, the provider did not supply patients with any additional

written information which was not included on the manufacturer's information leaflet about how they may need to take the medicine differently for an unlicensed indication.

The provider did not offer repeat prescriptions; patients had to have a consultation with a GP in order for a medicine to be prescribed. The service was not aimed at patients with long-term conditions that may need to be monitored, and the provider's policy was to only prescribe limited quantities of medicines in these circumstances. We reviewed medical records and found GPs declined to prescribe medicines where this was inappropriate, for example patients with complex mental ill health, requests for controlled drugs, and patients who had not verified their ID.

There were protocols in place for identifying and verifying the patient. When a patient registered with the service, they were required to supply a copy of photographic identification, and this was viewed alongside a "selfie" photograph also submitted by the patient, in order to verify their identity. However, we saw an example of a patient having a GP consultation and of a prescription being issued before their identity had been verified. However, the service provided evidence at the inspection that identity verification was only bypassed by the clinical team for clinical safety reasons where a patient had an urgent need for an appointment but could not supply documentation at that time of consultation and this would be risk assessed.

## Information to deliver safe care and treatment

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

## Management and learning from safety incidents and alerts

There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. The service had a clinical governance lead who was responsible for the investigation and reporting of incidents, and monthly governance meetings were held where these were discussed with the management team. We reviewed three incidents and found that these had been fully investigated, discussed and as a result action taken in the form of a change in processes.

## Are services safe?

The service had established processes in place to communicate learning from incidents to relevant staff. As part of the analysis of each incident, consideration was given to the appropriate means of communicating the learning with staff, including individual conversations with those involved in the incident, inclusion in the regular clinical staff bulletin, or via the staff communication online group.

From the incidents we viewed, we saw evidence which demonstrated the provider was aware of and complied with the requirements of the duty of candour by explaining to the patient what went wrong, offering an apology and advising them of any action taken.

There was evidence of monthly newsletters circulated to all staff by the governance team. The newsletters focused on shared learning including key themes from incident reviews and lessons learnt from investigations, as well as tips for best practice.

The provider had a system in place to receive and act on medicines and safety alerts, such as those issued by the Medicines and Healthcare products Regulatory Agency (MHRA).

# Are services effective?

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

## **Assessment and treatment**

There was limited evidence of patient outcomes therefore we reviewed 49 examples of medical records which demonstrated that, in most cases, each GP assessed patients' needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) evidence based practice.

We were told that each video consultation lasted for 10 minutes. If the GP had not reached a satisfactory conclusion we were told that GPs had the flexibility to extend the consultation.

When registering for the service, patients were able to input details about their past medical history. GPs completed notes of the consultation using a set template, which included the reasons for the consultation and the outcome, along with any notes about past medical history and diagnosis. Of the examples we viewed, we saw that, overall, adequate notes were recorded. However, we found that in a few cases GPs did not always record the rationale for prescribing decisions, for example when they had not followed national guidance. GPs had access to all previous notes.

We saw evidence that GPs providing the service were aware of both the strengths (speed, convenience, choice of time) and the limitations (inability to perform physical examination) of working remotely from patients. They worked carefully to maximise the benefits and minimise the risks for patients. If a patient needed further examination they were directed to an appropriate agency. If the provider could not deal with the patient's request, this was explained to the patient and a record kept of the decision.

The provider demonstrated that they had assured themselves that the app used to deliver digital consultations conformed to the requirements of NHS Digital Standard DCB 0129. (This standard provides a set of requirements suitably structured to promote and ensure the effective application of clinical risk management by those organisations that are responsible for the development and maintenance of Health IT Systems for

use within the health and care environment). They also demonstrated that they were compliant with the NHS Digital Standard DCB 0160 which relates to the deployment of such health technology by the provider.

## **Quality improvement**

The service took part in quality improvement activity with evidence of regular monitoring across a number of areas including reviews of consultations, prescribing trends and support team telephone performance. However, most activity was focused on improving processes rather than focusing on improving the quality of care and treatment patients received. There was limited evidence of two-cycle audit that clearly demonstrated improvements in clinical outcomes for patients.

## **Staff training**

All staff had to complete a comprehensive training programme which consisted of practical induction, systems and processes, policies, health and safety and information governance. GPs had to complete a phased induction including mock consultations, peer review and probation review. Staff also had to complete other training on a regular basis including safeguarding, basic life support and infection control. The training and development department had a training matrix which identified when training was due.

The GPs registered with the service had to receive specific induction training prior to treating patients. An induction log was held in each staff file and signed off when completed. Supporting material was available, for example, in short instructional videos and embedded within policies and guidance. We saw evidence that information was distributed to GPs to enable them to keep up to date with both internal and external changes, this was done via an internal messaging system. The GPs we spoke to told us they received support if there were any technical issues or clinical queries and could access policies. When updates were made to the IT systems, the GPs received further online training.

Administration staff received regular performance reviews. All the GPs had to have received their own appraisals before being considered eligible at recruitment stage and ongoing systems were in place to ensure that GPs kept up to date with their appraisal and professional registration.

## **Coordinating patient care and information sharing**



# Are services effective?

When a patient contacted the service, they were asked if the details of their consultation could be shared with their registered GP. If patients agreed we were told that a letter was sent to their registered GP in line with GMC guidance. We saw evidence of a significant improvement in the percentage of consultations that were now shared with a patients GPs since our last inspection.

At the inspection the provider told us that it was policy to allow patients one prescription of reliever inhalers for treating asthma to be given in the absence of consent to share this with a patient's GP. However, evidence gathered during the inspection showed that up to four prescriptions were prescribed without sharing this with a patients GP. (It would be important for a GP to know this information to avoid the risk of adverse effects on a patient's health). The provider acknowledged this as an area for improvement.

Where a patient required a referral to an external service, details were completed by the GP, and the referral was then sent to the appropriate service by the dedicated administrative team responsible for referrals. We saw evidence that this team kept up to date records of the referrals requested by GPs, and monitored when these

were processed. Where a referral was refused by the external organisation, this initially came to the administrative team, who had a process for monitoring refusals and identifying common trends in order to address any systemic issues. The service was able to provide examples of issues they had encountered in the past with referrals to certain external services being declined, which had been resolved following liaison with the provider to agree on an acceptable process. In these instances where referrals had been initially refused we noted that the provider had checked that affected patients were subsequently referred and checked they had been seen.

## **Supporting patients to live healthier lives**

The service provided advice on healthy living, such as lowering alcohol consumption, and the benefits of exercise, via their website and social media accounts.

Where appropriate, the service provided patients with advice and signposted to information on leading healthy lifestyles, such as information on smoking cessation or weight loss.



# Are services caring?

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

## **Compassion, dignity and respect**

We were told that the GPs undertook video consultations in a private room and were not to be disturbed at any time during their working time. The provider carried out random spot checks to ensure the GPs were complying with the expected service standards and communicating appropriately with patients. Feedback arising from these spot checks was relayed to the GP. Any areas for concern were followed up and the GP was again reviewed to monitor improvement.

We did not speak to patients directly on the day of the inspection. However, the provider had processes in place to

gather feedback from patients at the end of every consultation. Patients were asked to provide a star-rating out of five; where a patient scored their consultation as three stars or less, this would flag with the service's clinical governance team and prompt a review of the consultation. Evidence provided by the service showed that four and five-star ratings were consistently above 93%.

## **Involvement in decisions about care and treatment**

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

Patients could access notes of their consultations by signing into their account (either online or via the app); this included viewing a video of their consultation.

# Are services responsive to people's needs?

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

## **Responding to and meeting patients' needs**

Consultations were provided 24 hours a day, seven days a week, 365 days a year. This service was not an emergency service. Patients who had a medical emergency were advised to ask for immediate medical help via 999 or if appropriate to contact their own GP or NHS 111.

The digital application allowed people to contact the service from abroad but all medical practitioners were required to be based within the United Kingdom. Any prescriptions issued were delivered within the UK to a pharmacy of the patient's choice.

Patients signed up to receiving this service on a mobile phone (iPhone or android versions that met the required criteria for using the app) or online.

The provider made it clear to patients what the limitations of the service were.

Patients requested an online consultation with a GP and were contacted at the allotted time. The allocated length of time for a consultation was 10 minutes; however, we were told that GPs could extend a consultation if clinically necessary.

## **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.

There was no information available on the service's website about the GPs available. If a patient wished to consult with a GP of a particular gender or with a specific GP, they had to contact the service's customer service centre in order for this to be arranged; there was no facility for patients to select a specific GP via the online booking system or app.

We were told that "type talk" was available for visually impaired patients, and Language Line could be used by patients who required language translation.

## **Managing complaints**

Information about how to make a complaint was available on the service's website. The provider had developed a complaints policy and procedure. The policy contained

appropriate timescales for dealing with the complaint. There was escalation guidance within the policy. We reviewed the complaint system and noted that comments and complaints made to the service were recorded. The provider had received 36 complaints in the past 12 months. We reviewed, in detail, a randomised sample of complaints and found they were generally dealt with in a timely way. However, in one example we reviewed, the complaint was not adequately addressed by the service initially, which resulted in a further complaint from the patient; we saw no evidence that the service had reflected on their handling of this complaint in order to identify what they could have done differently.

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; for example, following a complaint about a prescribing error, we saw evidence that the service had delivered a presentation to its clinical team which outlined the learning.

There was evidence of monthly newsletters circulated to all staff by the governance team. The newsletters focused on shared learning including key themes from complaint reviews and lessons learnt from investigations, as well as tips for best practice.

## **Consent to care and treatment**

There was clear information on the service's website with regards to how the service worked and what costs applied including a set of frequently asked questions for further supporting information. The website had a set of terms and conditions and details on how the patient could contact them with any enquiries. Information about the cost of the consultation was known in advance and paid for before the consultation appointment commenced. There was no additional cost for the service issuing a prescription or medical certificate.

All GPs had received training about the Mental Capacity Act 2005. Staff understood and sought patients' consent to care and treatment in line with legislation and guidance. Where a patient's mental capacity to consent to care or treatment was unclear, the GP assessed the patient's capacity, and recorded the outcome of the assessment.

# Are services well-led?

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

## **Business Strategy and Governance arrangements**

The provider told us they had a clear vision to work together to provide a high quality responsive service that put caring and patient safety at its heart. The provider had a mission statement and supporting business plans.

There was a clear organisational structure and staff were aware of their own roles and responsibilities. There was a range of service specific policies which were available to all staff. Overall, the policies we reviewed reflected the service's current practices and processes.

There were a variety of daily, weekly and monthly checks in place to monitor the performance of the service. These included random spot checks for consultations. The information gathered from these checks was used by the service's clinical governance team in order to identify issues and trends, and was presented to the management team during monthly governance meetings. This ensured a comprehensive understanding of the performance of the service was maintained.

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

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

## **Leadership, values and culture**

The Medical Director had responsibility for any medical issues arising. They attended the service daily or were otherwise available. There were systems in place to address any absence of this clinician.

The service had an open and transparent culture. We interviewed by telephone a randomised sample of GPs who worked remotely, GPs present at the inspection, and a range of staff in non-clinical roles. All staff we spoke to told us that they felt able to speak up if they had a concern. They said their views were listened to and they were supported by the provider in all aspects of their role.

We were told that if there were unexpected or unintended safety incidents, the service would give affected patients reasonable support, truthful information and a verbal and written apology. This was supported by an operational policy.

## **Safety and Security of Patient Information**

Systems were in place to ensure that all patient information was stored and kept confidential.

There were policies and IT systems in place to protect the storage and use of all patient information. The service was registered with the Information Commissioner's Office. There were business contingency plans in place to minimise the risk of losing patient data.

## **Seeking and acting on feedback from patients and staff**

Patients could rate the service they received. This was constantly monitored and if fell below the provider's standards, this would trigger a review of the consultation to address any shortfalls.

There was evidence that the GPs were able to provide feedback about the quality of the operating system and any change requests were logged, discussed and decisions made for the improvements to be implemented. All the GPs we spoke to told us they felt involved in discussions about service improvements.

The provider told us they had a process of constant feedback and surveillance through in-app star ratings and comments box. Written and verbal feedback gathered by email, telephone, social media, review sites and the providers website. Feedback was collated and discussed widely as a team to improve the service provided.

We saw evidence of an action plan based on user feedback and evidence that the provider had acted on complaints. For example, as a consequence of a complaint relating to a prescribing error, the provider had disseminated a presentation to all the GPs on prescribing to minimise the risk of similar errors reoccurring.

The provider had a whistleblowing policy in place. (A whistle blower is someone who can raise concerns about practice or staff within the organisation.) There was an in-house team responsible for dealing with any issues raised under whistleblowing. However, the whistleblowing policy did not provide sufficient detail for raising concerns with external bodies. The policy encouraged whistle blowers to report concerns internally or to seek advice from an independent charity before raising concerns with external organisations. However, the policy did not make clear which specific external organisations concerns could be reported to.

# Are services well-led?

## Continuous Improvement

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

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

The service was committed to the use of new technology in order to improve the patient experience and clinical

outcomes, and to ensure that GPs can use their time productively. For example, during the inspection, the service demonstrated technology they were developing which used facial mapping to provide consulting doctors with additional, non-verbal, information about the way the patient was feeling. They were also developing technology to assist consulting doctors with making records of consultations using voice recognition software.