Ada Digital Health Ltd

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Inspection report

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Ada Digital Health Ltd on 2 May 2017.

Ada Digital Health Ltd operates a free app which can be downloaded onto a mobile device, where patients can enter information about their symptoms and medical history; the app will then provide suggested diagnoses. The patient then has the option to pay for one of Ada's GPs to review the answers they provided via the app, along with additional information provided in free-text by the patient; the GP will then provide a tailored opinion, and will issue a prescription if appropriate, which is sent directly to the pharmacy of the patient's choice.

Overall, we found this service provided effective, caring, and responsive and well led services in accordance with the relevant regulations; however, we identified some areas relating to the safe provision of services where the provider must make improvements.

Our key findings were:

- Patients access the service via a free app, with the option of paying for a personalised consultation with a GP. Consultations were primarily conducted via a web chat; however, there was the facility for GPs to phone patients if necessary. Once a patient had paid for a personalised consultation and supplied relevant information about their symptoms, the service aimed to respond the same day (if submitted before 7pm).
- Systems were in place to protect personal information about patients. The company was registered with the Information Commissioner's Office and supporting procedures were in place to ensure that individuals were aware of their responsibilities with regards to the security of patients' information.
- There was a comprehensive system in place to check the patient's identification prior to advice and treatment being provided.
- The service shared information about treatment with the patient's own GP in line with General Medical Council guidance.
- Prescribing was monitored to prevent any misuse of the service by patients and to ensure GPs were prescribing appropriately.
- There were systems in place to mitigate safety risks including analysing and learning from significant events and safeguarding.
- The provider was aware of and complied with the requirements of the Duty of Candour.
- Overall, there were appropriate procedures in place in relation to the recruitment of staff, and these were followed in the recruitment of clinical staff; however, when recruiting non-clinical staff the provider had not always ensured that appropriate background checks were carried-out. The provider's policy relating to pre-employment background checks was not effective to enable the provider to be sure that candidates were safe to work with vulnerable people.

Summary of findings

- An induction programme was in place for all staff and GPs registered with the service received specific induction training prior to treating patients. Staff, including GPs working remotely, also had access to all policies.
- Patients were treated in line with best practice guidance and appropriate medical records were maintained.
- Information about services and how to complain was available. At the time of the inspection the service had not received any formal complaints; however, we saw evidence that mechanisms were in place for complaints to be discussed and used to drive improvement.
- Patient feedback and consultation records we viewed showed that patients were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- There was a clear business strategy and plans in place.
- Staff we spoke with were aware of the organisational ethos and philosophy and told us they felt well supported and that they could raise any concerns.
- There were clinical governance systems and processes in place to ensure the quality of service provision.
- The service encouraged and acted on feedback from both patients and staff.

We identified regulations that were not being met (please see the requirement notices at the end of this report). The areas where the provider must make improvements are:

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

The areas where the provider should make improvements are:

- Consistently follow their newly introduced appraisal arrangements for non-clinical staff.
- Provide training on the Mental Capacity Act to all staff.
- Put processes in place to monitor when staff training is due.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

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 in some areas this service was not providing safe care in accordance with the relevant regulations.

- Appropriate recruitment checks were in place for clinical staff; however, when recruiting non-clinical staff the provider had not always ensured that appropriate background checks were carried-out.
- There were systems in place to protect all patient information and ensure records were stored securely. The service was registered with the Information Commissioner's Office. Patient identity was verified by checking personal information provided by patients against their credit card details. Prior to a prescription being issued, patients were required to provide photographic identitfication. In the event of a medical emergency occurring during a consultation, systems were in place to ensure emergency services were directed to the patient. The service had a business contingency plan.
- Processes were in place for prescribing to be monitored. At the time of the inspection the service was carrying-out small numbers of consultations, and these were reviewed and discussed amongst the clinical team. The service had a process in place to assess consultation requests by risk, and all requests were flagged using a "traffic light" system.
- There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members.
- The provider was aware of and complied with the requirements of the Duty of Candour and encouraged a culture of openness and honesty.
- There were enough GPs to meet the demand of the service.
- All staff had received safeguarding training appropriate for their role. All staff had access to local authority information if safeguarding referrals were necessary.
- There were systems in place to meet health and safety legislation.

Are services effective?

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

- Consent to care and treatment was sought in line with the providers policy. All of the GPs had an appropriate awareness of the Mental Capacity Act.
- We were told that each GP assessed patients' needs and delivered care in line with relevant and current evidence based guidance and standards, for example, National Institute for Health and Care Excellence (NICE) evidence based practice. We reviewed a sample of anonymised consultation records that demonstrated appropriate record keeping and patient treatment.
- The service had arrangements in place to coordinate care and share information appropriately. Patients' registered GPs were always informed when a prescription was issued.
- The service's website contained information to help support patients lead healthier lives, and information on healthy living was provided in consultations as appropriate.
- GPs were employed for set sessions, and when they were not occupied providing direct patient care, they were expected to contribute to the quality assurance of the service by reviewing the decisions made by the app.

Summary of findings

- There were induction, training, monitoring and appraisal arrangements in place to ensure clinical staff had the skills, knowledge and competence to deliver effective care and treatment; however, at the time of the inspection, there were no formal performance review arrangements in place for non-clinical staff.

Are services caring?

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

- We were told that GPs undertook consultations in a private room; for example, in the service's head office or the GP's own home. The provider had plans in place to carry-out random spot checks to ensure GPs were complying with the expected service standards and communicating appropriately with patients.
- We did not speak to patients directly on the days of the inspection; however, we reviewed examples of patient feedback on the personalised GP text consultations. At the time of the inspection the service had only been operating for three weeks, and therefore there was limited feedback available for us to view; however, we saw evidence that the service responded appropriately to all feedback provided.

Are services responsive to people's needs?

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

- There was information available to patients to demonstrate how the service operated.
- Ada Digital Health Ltd operates a free app, where patients can enter information about their symptoms and medical history; the app will then provide suggested diagnoses. The patient then has the option to pay for one of Ada's GPs to review the answers they provided via the app, along with additional information provided in free-text by the patient, and conduct a consultation via a web chat. The GP would provide advice and will issue a prescription if appropriate, which was sent directly to the patient or the pharmacy of the patient's choice. The service aimed to make contact with patients who purchased a consultation the same day (provided the consultation is purchased before 7pm). There were no limits placed on the duration of the consultation with GPs.
- Patients were not able to choose which GP they consulted with. The symptom assessment app could be accessed in a variety of different languages; however, personalised consultations were conducted in English. The service told us that they were looking into introducing a translation facility for personalised consultations in the future.
- There was a complaints policy which provided staff with information about handling formal and informal complaints from patients.

Are services well-led?

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

- Systems were in place to ensure that all patient information was stored and kept confidential; however, the service did not have arrangements in place to ensure that patient information was stored in line with legal requirements in the event that they ceased trading.
- There were business plans and an overarching governance framework to support clinical governance and risk management.
- There was a management structure in place and the staff we spoke with understood their responsibilities. Staff were aware of the organisational ethos and philosophy and they told us they felt well supported and could raise any concerns with the provider or the manager.

Summary of findings

- The service encouraged patient feedback. There was evidence that staff could also feedback about the quality of the operating system and any change requests were discussed.
- The service was in the process of working with two NHS providers to pilot the use of the symptom assessment app for their patients. The service's vision was that the app would act as an information gathering tool which GPs and urgent care centres could access to appropriately triage patients or signpost them to appropriate alternative sources of advice.

Ada Digital Health Ltd

Detailed findings

Background to this inspection

Background

Ada Digital Health Ltd operates a free app, where patients can enter information about their symptoms and medical history; the app will then provide suggested diagnoses. The patient has the option to pay for one of Ada's GPs to review the answers they provided via the app, along with additional information provided in free-text by the patient, and conduct a consultation via a web chat. The GP will provide advice and will issue a prescription if appropriate, which is sent directly to the patient or the pharmacy of the patient's choice

A registered manager is in place. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like 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.

How we inspected this service

Our inspection team was led by a CQC Lead Inspector accompanied by a second CQC Inspector, a GP Specialist Advisor and two CQC Pharmacist Specialist Advisors.

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew.

During our visits we:

- Spoke with a range of staff.
- Reviewed organisational documents.
- Examined anonymised patient records.

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.

Why we inspected this service

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

Are services safe?

Our findings

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

Safety and Security of Patient Information

Systems were in place to ensure that all patient information was stored and kept confidential; however, the provider did not have arrangements in place to ensure that patients' records would be kept in line with legal requirements in the event that the provider ceased trading.

The provider made it clear to patients what the limitations of the service were. There were processes in place to manage any emerging medical issues during a consultation. The service was not intended for use by patients with either chronic conditions or as an emergency service. In the event an emergency did occur, the provider had systems in place to ensure the location of the patient at the beginning of the consultation was known, so emergency services could be called.

On first use of the app, patients provided personal information. Additional information was provided by the patient when they purchased a personalised consultation with a GP, and at each consultation, GPs had access to the patient's previous records held by the service. Before issuing a prescription, the patient was required to provide photographic ID, and there was a function built into the app to allow patients to upload a photograph of their passport or driving licence. The service was intended to be used by people aged over 18 years and prescriptions would only be issued to patients aged over 18 years; however, there was the option for users to declare that they were completing the symptom assessment and consulting with a GP on behalf of someone else, and therefore, clinical advice could be given relating to patients aged under 18.

The free app function which provided patients with suggested diagnoses produced a report which patients could download. The personalised web chat consultation with a GP was saved within the patient's account and could be accessed by the patient at any time.

The provider explained that they were constantly reviewing the service and seeking feedback which could be used to make improvements. They were aware that many of their processes, such as the process for producing prescriptions, were currently manual and would require further development as the business expanded.

Prescribing safety

At the time of the inspection the service had not issued any prescriptions; however, they did have procedures in place which outlined the processes they would use to ensure that medicines prescribed to patients were monitored. If a medicine was deemed necessary following a consultation, the GPs were able to issue a private prescription to patients. The GPs could only prescribe from a set list of medicines, and this was reviewed monthly by a pharmacist employed by the service. There were no controlled drugs on this list. There were systems in place to prevent misuse of certain medicines, for example, the service would only prescribe inhalers to treat asthma if the patient provided evidence that this medicine had been prescribed to them previously by their registered GP; the service would only prescribe an asthma inhaler to a patient once in any 12 month period. The service would only issue a prescription if the patient agreed to information about the prescription being shared with their registered NHS GP.

The service informed us that once a GP selected the medicine and correct dosage of choice, relevant instructions would be given to the patient regarding when and how to take the medicine, the purpose of the medicine and any likely side effects and what they should do if they became unwell. As the service had not yet issued any prescriptions, we were unable to see an example of this.

For medicines requested by a patient which they had previously received via a repeat prescription from their usual GP, the service's policy stated that they would only issue a prescription if the patient could provide a copy of the previous repeat prescription. As with all prescriptions issued by the service, the patient's usual GP would be informed of the prescription being issued. The service prescribed antibiotics for skin infections and urinary tract infections; their prescribing guidelines were based on national guidance.

The service had plans in place to monitor their prescribing activity via audits which would be carried-out by their pharmacy lead. Individual prescribing decisions were made with reference to previous medical records held by the service.

Are services safe?

There were protocols in place for identifying and verifying the patient prior to a consultation by checking personal information provided by patients against their credit card details. Prior to a prescription being issued, patients were required to provide photographic identitfication.

Once the decision was made for a prescription to be issued, the patient was asked to nominate a pharmacy of their choice for the prescription to be sent to. The prescription was sent to the pharmacy electronically (followed by a hard copy).

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. We reviewed one incident, which came to the attention of the provider via the patient feedback function, where a patient had commented that they had paid for a personalised consultation but had not received a service. The provider had investigated the reason for this and identified a systemic problem, which was subsequently resolved.

As a small team, learning from incidents was immediately shared with relevant members of staff via informal discussions. The provider had also scheduled monthly staff meetings, during which learning from incidents would be shared.

We saw evidence from two incidents 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.

The systems in place at the time of the inspection for dealing with medicine safety alerts required review. The process was for a non-clinical member of staff to receive alerts and make a decision about whether it was relevant for distribution to the clinical team. Following the inspection the provider revised these arrangements and nominated one of the clinical leads as being responsible for reviewing all updates and alerts. They provided us with evidence that their operating policy had been updated with this new arrangement.

Safeguarding

We saw evidence that all staff had received training in safeguarding and whistleblowing to a level appropriate to their role. All staff we spoke to could describe the signs of abuse and to whom to report them. All the GPs had received level three child safeguarding training and adult safeguarding training. It was a requirement for the GPs registering with the service to provide safeguarding training certification. All staff had access to safeguarding policies and could access information about who to report a safeguarding concern to.

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 provider had a selection process in place for the recruitment of all staff; however, at the time of employing two initial non-clinical members of staff, the provider did not have a recruitment policy in place. The provider failed to retrospectively apply the subsequent policy, and therefore there was no evidence of background checks having been carried-out for these staff members. The service's recruitment policy stated that prior to employment candidates should be in possession of a Disclosure and Barring Service (DBS) check dated within the past three years; however, the service was unable to evidence that they had taken action to assure themselves that candidates did not have any criminal convictions from the period following the date of the DBS check. Prior to employment the service checked that candidates for GP positions were appropriately qualified, registered with the General Medical Council, were up to date with their appraisal, and had received recent training in safeguarding. The provider's policy stated that prior to commencing employment, GPs should hold appropriate medical indemnity insurance; however, we found one example of the service failing to adequately record the checks that had been carried-out to confirm that a GP had the necessary insurance in place.

Monitoring health & safety and responding to risks

The service had performed a risk assessment of their operational activity and had put in place measures to mitigate the risks identified. For example, they had carefully considered the list of medicines available for GPs to prescribe in order to ensure manage the risks associated

Are services safe?

with remote prescribing. The service had a “traffic light” system for rating requests for a clinical consultation by risk. This was an automated process based on the information provided by the patient via the symptom assessment app..

The provider’s headquarters was located within modern purpose built offices, housing the management team, administrative support team and some clinical staff (others were home based and carried out online consultations remotely, usually from their home). Patients were not treated on the premises. Administration staff 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 their laptop to log into the operating system, which was a secure programme.

Are services effective?

(for example, treatment is effective)

Our findings

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

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 personalised consultation commenced. There was no further cost for a prescription to be issued, and we were told that patients would be informed of the need to pay their selected pharmacy for their medicine when they collected it.

Staff understood and sought patients' consent to care and treatment in line with legislation and guidance.

Staff had not received formal training about the Mental Capacity Act 2005 via the service; however, clinical staff we spoke to could demonstrate that they had a good understanding of their responsibilities in relation to seeking patients' consent to care and treatment in line with legislation and guidance.

Assessment and treatment

We reviewed medical records of all nine consultations that the service had conducted during the three weeks that they had been operational, and found that 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 there was no limit to the duration of each personalised consultation, and there were processes in place for GPs to contact patients following the initial web chat to check that any treatment suggested or prescribed had been effective.

Patients initially entered their symptoms into the app and then answered a series of both general questions (such as whether the patient was pregnant) and questions specific to the symptoms entered. The app then produced a report which provided suggested diagnoses. The patient then had the option to pay for a personalised consultation with a GP via a web chat. Once a personalised consultation was purchased, the previously generated report was sent through to the GP, along with any additional information that the patient chose to provide via a open text box. The GP would consider the information provided by the patient and request further details about their symptoms and medical history where necessary. In addition to the information supplied by the patient for the current consultation, the GPs also had access to all previous notes generated by the service.

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

The service monitored consultations and planned to carry-out consultation and prescribing audits to improve patient outcomes. The service's staffing policy stated that clinicians would receive six-monthly appraisals, during which a sample of their consultations would be reviewed. They had also scheduled monthly clinical meetings, which were attended by all GPs (either in person or via video link) which were an opportunity for specific cases to be discussed and changes to the service to be considered. Regular clinical governance meetings were also scheduled.

GPs were employed for set sessions, and when they were not occupied providing direct patient care, they were expected to contribute to the quality assurance of the service by reviewing the decisions made by the app.

Coordinating patient care and information sharing

When a patient entered details via the symptom assessment app, a report was produced, which summarised the information they had entered and the possible diagnoses; this report could be downloaded as a PDF file, which the patient could provide to their registered GP. At the time of the inspection the service did not routinely offer to share details of the consultation with the patient's registered GP; however, this was something that they were in the process of implementing, with a target timescale of the end of May 2017. If a prescription was issued the registered GP was always notified by the service; a prescription would not be issued unless the patient had

consented to this information being shared. The service intended to conduct quarterly audits of cases where a prescription could not be issued due to the patient refusing to consent to their information being shared. This would enable them to determine whether there were certain circumstances whereby it would be in the best interest of the patient to issue a prescription even if they did not consent to their registered GP being notified. For medicines requested by a patient which they had previously received via a repeat prescription from their registered GP, the service's policy stated that they would only issue a prescription if the patient could provide a copy of the previous repeat prescription.

Supporting patients to live healthier lives

The service identified patients who may be in need of extra support and provided links to websites which contained helpful information. For example, we saw that where a patient had consulted with the service in relation to feelings of anxiety, the GP had provided links to websites which provided advice on cognitive behavioural therapy and information on breathing exercises.

Staff training

All staff had to complete induction training which consisted of learning about the workings of the service's IT systems, an introduction to the service's policies and procedures, responsibilities in relation to patient confidentiality, and training on effective communication specific to text-based consultations. Staff also had to complete other training on a regular basis such as child and adult safeguarding and information governance. The operations manager was responsible for co-ordinating the induction and training for all staff, but at the time of the inspection there was no clear record in place to identify when update training was due.

The GPs told us they received excellent support if there were any technical issues or clinical queries and could access policies. When updates were made to the IT systems, the GPs received further online training.

At the time of the inspection neither of the administrative staff had received a performance review, and arrangements for the performance monitoring of administrative staff was not included in the service's procedure. Following the inspection the service provided evidence to show that their staff supervision policy had been updated to include non-clinical staff, and that appraisals for these members of staff had now been completed. The service's staffing procedure stated that all GPs would receive an appraisal one month after joining the service and six-monthly thereafter, where a sample of their consultations would be reviewed and discussed. We were told that the service would expect that GPs who were also required to have an NHS GP appraisal would declare the work that they undertook for the service to their appraiser so that this could be included in the appraisal process; however, this expectation was not formalised in the service's staffing policies.

Are services caring?

Our findings

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

Compassion, dignity and respect

We were told that the GPs undertook consultations in a private room and were not to be disturbed at any time during their working time. The provider carried-out reviews of consultations as part of GPs' six-monthly appraisals to ensure the GPs were complying with the expected service standards and communicating appropriately with patients.

We did not speak to patients directly on the days of the inspection. However, we reviewed examples of patient feedback relating to the symptom assessment app, and two examples of patient feedback specifically relating to the personalised GP consultations. These two pieces of feedback highlighted problems that patients had experienced in accessing their account, and in both cases, the service provided an apology, fully or partially refunded the fee that the patient had paid, and used the information provided by the patient to identify a problem with the IT system, which was subsequently fixed.

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.

We saw evidence that all GPs introduced themselves to patients at the beginning of a personalised web chat consultation. Patients did not have the option to consult with the GP of their choice or to specify whether they consulted with a male or female GP; however, the service was considering whether this would be appropriate if they were to introduce a video chat service. The symptom assessment app could be accessed in a variety of different languages, but at the time of the inspection the personalised web chat consultation could only be conducted in English. The service was looking into ways to allow web chats to be translated.

The service had only been operational for three weeks at the time of the inspection and had conducted nine personalised consultations. They had not received a star rating from any of these patients, and had identified the need to make the rating link more prominent to patients. The symptom assessment app, which had been operational for approximately five months, had an average rating of 4.7 out of 5 from users.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting patients' needs

Patients signed up to receiving this service on a mobile device (iOS or android versions that met the required criteria for using the app). Patients could use the symptom assessment app at any time. When a personalised consultation was requested, the service aimed to respond on the same day for those requested before 7pm. 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.

Patients who purchased a personalised consultation with a GP were able to provide additional information about their condition and the GP then contacted them via a web chat. There were no limits put on the duration of the consultation.

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 on the service's website about the individual GPs available for consultations, and patients were unable to choose which GP they consulted with. The service explained that if they were to introduce an online video consultation, they would allow patients to choose a specific GP.

The symptom assessment app could be accessed in a variety of different languages; however, personalised consultations were conducted in English. The service told us that they were looking into introducing a translation facility for personalised consultations in the future.

Managing complaints

Information about how to make a complaint was available on the service's web site. The provider had developed a complaints policy and procedure. The policy contained appropriate timescales for dealing with the complaint. The service had not received any formal complaints during the time that they had been operational; however, they had received two pieces of negative feedback about the service, both of which led the service to identify problems with their programming which they had not been aware of, which were subsequently resolved. We saw evidence that the patients who provided this feedback were contacted and provided with an explanation and apology and a full or partial refund of the fee they had paid.

Are services well-led?

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

Our findings

We found that this service was providing well led services 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 patient safety at its heart. We reviewed business plans that covered the next two years which outlined how the business would be promoted and scaled up.

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

There were a variety of daily, weekly and monthly checks in place to monitor the performance of the service. These included six-monthly reviews of consultations with GPs as part of their appraisal. The service intended to hold monthly clinical meetings in order to discuss the performance of the service; however, as the service had only been operational for three weeks at the time of the inspection, these meetings had not yet been carried-out.

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

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

Leadership, values and culture

The Chief Medical Officer had overall responsibility for the service. Two clinical leads were employed to oversee the work of the GPs, and two operations managers were responsible for the management of the administrative side of the service. The Chief Medical Officer and Operations Managers worked from the service's headquarters and attended the service daily. Both of the Clinical Leads worked part time and provided full-time cover of the role between them. At the time of the inspection the service was in the process of recruiting additional GPs and administrative staff.

The service's stated aims and objectives were to deliver "high quality, customer-centric care that is delivered with compassion and integrity in a comfortable and appropriate manner".

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

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

Seeking and acting on feedback from patients and staff

Patients could rate the service they received; however, at the time of the inspection the service had not received any ratings relating to the personalised GP consultations. They had identified the need to make the rating link more prominent to patients. In addition, patients could post comments or suggestions online. Patient feedback was published via the Ada app.

GPs were able to provide feedback about the quality of the operating system and any change requests were logged, discussed and decisions made for the improvements to be implemented.

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

Continuous Improvement

The service consistently sought ways to improve. All staff were involved in discussions about how to run and develop the service, and were encouraged to identify opportunities to improve the service delivered. We saw evidence that monthly clinical meetings were scheduled to allow GPs the opportunity to discuss consultations and other relevant clinical issues.

At the time of the inspection the staff team was small, and therefore, we were told that there were ongoing discussions at all times about service provision. However,

Are services well-led?

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

we also saw evidence of documented meetings having taken place and of a regular management and clinical meetings being scheduled going forward. There was a quality improvement strategy and plan in place to monitor quality and to make improvements; for example, all GPs were involved in developing the symptom assessment app. This involved GPs reviewing symptoms entered into the app by anonymised users and producing a diagnosis; this data was then fed back into to app in order to improve accuracy.

The service was in the process of working with two NHS providers to pilot the use of the symptom assessment app for their patients. The service's vision was that the app would act as an information gathering tool which GPs and urgent care centres could access to appropriately triage patients or signpost them to appropriate alternative sources of advice.

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
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had failed to establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care. Specifically: · The provider had failed to maintain a complete record in relation to all persons employed. · The provider's policy relating to pre-employment background checks were not effective in checking whether the candidate was safe to work with vulnerable people. · The provider did not have arrangements in place to ensure that patients' records would be kept in line with legal requirements in the event that they were to cease trading. This was a breach of regulation 17 (1) (2)