The GP Service (UK) Ltd

Inspection report

The Technocentre
Coventry University Technology Park, Puma Way
Coventry
West Midlands
CV1 2TT
Tel: 0247 615 8050
www.thegpservice.co.uk

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Overall summary

Letter from the Chief Inspector of General Practice

We rated this service as Good overall. This provider was previously inspected on 22 February 2018, but they were based at a different location. They have since re-registered with the CQC. This provider has not been rated before this inspection.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced inspection at The GP Service (UK) Limited on 12 June 2019 as part of our inspection programme. The GP Service (UK) Limited is an online provider. Patients are able to consult with a qualified General Medical Council registered GP via online assessment questionnaires or through secure video calling. Medicines can then be sent to the pharmacy of their choice for dispensing.There are a number of pharmacies which are signed up as affiliated pharmacies with The GP Service (UK) Limited.

At this inspection we found:

- The service had effective systems to manage risk so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes.
- The service routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- Patients could access care and treatment from the service within an appropriate timescale for their needs.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser and a member of the CQC medicines team.

Background to The GP Service (UK) Ltd

The GP Service (UK) Limited launched its online service in February 2017. It was previously based in central London. The service has been registered at the current location in Coventry since July 2018.

Patients from anywhere in the UK can consult with GPs via online assessment questionnaires and through secure video calling. The operating model of the service enables any medicines prescribed following consultations, to be available for collection through independent pharmacies signed up to the GP Service (UK) Limited scheme, or a pharmacy of the patient's choice if they prefer.

We inspected The GP Service (UK) Limited at the following address from where the provider is registered to provide services:

The Technocentre, Coventry University, Coventry, West Midlands, CV1 2TT

The service is led by a chief executive officer (CEO) and supported by a leadership team of four, which includes medical, technological and sales expertise. There are six GPs who carry out the online consultations remotely.

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

Before the inspection we gathered and reviewed information from the provider. During this inspection we spoke with the registered manager and members of the management and administration team.

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

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

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

Good

Are services safe?

We rated safe as Good because:

•The practice had a system for dealing with patient safety alerts. We saw that they were cascaded through emails and newsletters.

•We saw that when medicine errors happened there was reporting and discussion through meetings with the Medical Director, the Clinical Director and the clinical pharmacist.

•Validation checks were in place to verify patient identity.

•We saw that prescribing medicines that can be abused was prohibited and where large quantities or frequent smaller quantities of any medicine were prescribed, this was routinely monitored with an alert sent to the Medical Director.

•Patients' previous history was available through access to the patient's NHS summary care record and any previous consultation notes. This included allergies, regular medicines and a summary of the patients history, patient & practice details.

Keeping people safe and safeguarded from abuse

Staff employed at the headquarters had received training in safeguarding and whistleblowing and knew how to recognise the signs of abuse. All staff had access to the safeguarding policies and where to report a safeguarding concern. All the GPs had access to a link which enabled them to find the nearest appropriate organisation who could help where GPs were concerned about a vulnerable patient. 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 registered manager ensured they kept up to date and had a training matrix which indicated when further training was required.

The service did not treat children.

Monitoring health & safety and responding to risks

The provider headquarters was located within modern offices which housed the IT system and a range of administration staff. Patients were not treated on the premises as GPs carried out the online consultations remotely, usually from their home. The GPs had laptops provided by the provider. During the inspection we had a demonstration of laptop log in and consultation using a virtual private network plug in device. The provider used an embedded video consultation screen which allowed notes to be written in real time as the consultation progressed. 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 patient 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.

There were processes in place to manage any emerging medical issues during a consultation and for managing test results and referrals. The service was not intended for use by patients with either long term conditions or as an emergency service. 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.

Clinical consultations were assessed by GPs for risk and if the GP thought there may be serious concerns that required further attention. Consultations identified as higher or intermediate risk were reviewed with the help of the administrative and medical team.All risks were discussed at monthly clinical meetings. There were protocols in place to notify Public Health England of any patients who had notifiable infectious diseases.

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. The Medical Drector, Clinical Director, the Clinical Pharmacist and the Chief Operating Officer attended these meetings. We saw evidence of meeting minutes to show where some of these topics had been discussed, for example improvements to the consent policy, a significant incident and clinical pathways in line with national guidance.

Staffing and Recruitment

There were enough staff, including GPs, to meet the demands for the service and there was a rota for the GPs. There was a support team available to the GPs during consultations and a separate IT team. The prescribing GPs were paid on a sessional basis.

Good

Are services safe?

The clinical pharmacist produced a newsletter to provide information on NICE guidance, MHRA alerts and patient safety information. The organisation used the email system to provide immediate information with monthly newsletter distributed to all staff.

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.)

They had to provide evidence of having professional indemnity cover (to include cover for video consultations), an up to date appraisal and certificates relating to their qualification and training in safeguarding and the Mental Capacity Act.

We reviewed two recruitment files which showed the necessary documentation was available. The GPs could not be registered to start any consultations until these checks and induction training had been completed. This included the completion of several test scenario consultations. The provider did do prescribing audits and consultation audits post induction. When a new doctor started working for the organisation their consultation notes were audited for two weeks and longer if required. 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.

Prescribing safety

All medicines prescribed to patients from online forms and during a consultation were monitored by the provider to ensure prescribing was evidence based. If a medicine was deemed necessary following a consultation, the GPs could issue a private prescription to patients. There were no controlled drugs on this list and limited quantities of medicines prescribable on the system. This could be overridden but an alert was sent to the Medical Director with overridden medicine prescribed information. The system had a pop up feature which appeared when a consultation started. This listed all medicines issued within the last 28 days. The medical team carried out regular audits to identify patterns of someone getting scripts for smaller amounts too often. Clinicians would bring this to the attention of the medical team if patterns were identified. Once the GP prescribed the medicine and dosage of choice, relevant instructions were given to the patient regarding when and how to take the medicine, the purpose of the medicine and any likely side effects and what they should do if they became unwell.

The provider prescribed some licensed medicines and medicines for unlicensed indications, for example for jet lag and altitude sickness. (Medicines are given licences after trials which show they are safe and effective for treating a condition. When a medicine is used for a different medical condition that is listed on their licence it is called 'unlicensed use'. The use of unlicensed medicines is a higher risk because less information is available about the benefits and potential risks.) There was clear information on the website to explain that the medicines were being used outside of their license and the patient had to acknowledge that they understood this information. Additional written information to guide the patient when and how to use these medicines safely was supplied with the medicine.

For off license medicine used in jet lag and altitude sickness a form was completed on the website which gave information to the patient. In relation to one medicine, for example, it stated that this was off label and gave a brief overview of the effectiveness and stated that possible side effects had not been studied. However, it did not give information regarding the possible risks and side-effects of it being off label to the patient. The policy was changed after the inspection to confirm that the manufacturer would not be held responsible for any side effects following the prescribing of off licence medicines. The patients were told that the responsibility for these medicines lay with the prescriber.

A patient information leaflet was sent electronically for all form based treatments. The pharmacy was responsible for providing patient information leaflets with all medicines that were dispensed. Additional information was often provided by the doctor to patients via hyperlinks to relevant resources. Pharmacies could reject the prescription if they felt the patient was medically unsafe as part of the process. This would then be flagged as an incident.

Good

Are services safe?

Prescribing for long term conditions and high-risk medicines was limited to emergency supply of a few days with checks on test results and summary care records as part of the process.

There were protocols in place for identifying and verifying the patient and General Medical Council guidance was followed. An ID check was completed on customer log in. This included a photographic check. There was a system whereby the credit card payment had to be in the patient's name otherwise they could not continue with the consultation. If the credit card was not in their name they could not place the order. There was a system which flagged up about multiple identities. So therefore if someone tried to use the same telephone number or email address it would flag up with the provider on the system.

Previous prescriptions from this online provider were seen on medical records, prior to issuing any further prescriptions during consultations. The provider had read-only access to the summary care record. If prescribing was blocked, then no prescription or fit note could be issued, however GPs could still talk to patients. A consultation could not be ended until all the mandatory safe information was completed. An onward referral letter could be generated as a secure document to send to a specialist when required. Additional hyperlinks could be added to free type boxes. For example, hyperlinks to videos of inhaler use.

The prescription was sent electronically to a dedicated pharmacy and retrieved via a secure terminal in the dispensary. Portal access was controlled via password and a unique user name for the pharmacy which provided a two factor authentication process. Patients provided identification when presenting at the pharmacy to pick up the medicine. Once dispensed this was acknowledged by the pharmacy and signed off on the system. Any non-dispensed or non-collected item would trigger an alert after seven days. This was followed up with a phone call to the pharmacy to discuss the issue and arrange alternative dispensing where appropriate. Once the process was completed a questionnaire was generated for the patient to comment on the process with the pharmacy. This was included in the seven day follow up email generated by the provider.

Following our inspection the provider added an additional feature where a 'pop-up' message appeared in the middle of the screen as soon as a GP began a consultation, which showed details of any medicines that the patient had been issued within the last 28 days. The consulting GP must acknowledge that they have read the message before commencing the consultation.

The organisation was part of the national pilot scheme for accessing patient NHS summary care records (SCR) and was carrying out a proof of concept study. They verified consent from the patient to access the SCR first. If the patient had not given access to the summary care record before the consultation, they would try to obtain permission during the consultation. There was a timed automatic email issued if a follow up consultation was required. They had read only access for this and could see the patient's history in terms of allergies, previous medicines and which practice they were registered with. The provider informed the patient's GP following consultations.

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. 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.

We saw that an incident had been recorded where a GP had carried out a patient consultation in their garden. The patient raised concerns about confidentiality. The provider called the patient to apologise and spoke to the GP concerned as well. The clinical director spoke with the GP concerned to raise the confidentiality issue. The outcome was that an aide memoir was introduced by the provider to ensure confidentiality was abided by. Policies were updated to ensure that office environments were utilised for consultations.

We saw evidence from 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.

Good

Are services safe?

The provider had a system in place to assure themselves of the quality of the dispensing process (for onsite pharmacies). There were systems in place to ensure that the correct person received the correct medicine. During the inspection we saw evidence that the last three patient safety alerts were received and actioned. In May 2019 the provider discussed antimicrobial prescribing and a reminder was sent about prescribing a medicine and guidance around pregnancy prevention. In March 2019 there had been a discussion on the risks in pregnancy and an update on the combined hormonal contraceptive tablet clinical guidance.

Good

Are services effective?

We rated effective as Good because:

Patients' needs were effectively assessed, and care and treatment were delivered in line with current legislation, standards and evidence-based guidance.

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

•The provider had risk assessed the treatments it offered.

Assessment and treatment

We reviewed 10 examples of medical records that demonstrated 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. Patients completed an online form which included their past medical history. There was a set template to complete for the consultation that included the reasons for the consultation and the outcome to be manually recorded, along with any notes about past medical history and diagnosis as they could access the summary care record (SCR). We reviewed 10 anonymised medical records which were complete records. We saw that adequate notes were recorded, and the GPs had access to all previous notes. However, we saw one example where no record of body mass index was recorded for oral contraceptives. There was no system to confirm that blood pressure had been checked by the pharmacist for oral contraceptives. This process was changed following the inspection and an alert was added to the system to highlight this.

We were told that each online consultation lasted for 10 minutes on average. The provider shared some examples when occasionally the length of time went over this. There was no penalty if this happened for the provider or the patient.

A prescribing formulary was in place with access restricted so that GPs could not issue a prescription to a medicine that had been blocked. The formulary was based on the NHS database, produced by the medical team in which they had removed controlled drugs and sedatives. The formulary was reviewed by the clinical pharmacist and the prescribing committee. There was an ongoing six-monthly planned review with emergency changes such as the removal of some drugs where the controlled drugs classification had changed. The formulary then pre-populated the condition for each GP to prescribe appropriately. They would advise the GP if the same product was picked as previously dispensed. We saw examples of this during the inspection and were satisfied with the process in place. The provider did audits of prescribing which confirmed they were prescribing in line with NICE guidance.

We saw written protocols for antibiotics and antidepressants. The provider used NICE guidance where possible, however they had used Cochrane (systematic) reviews for jet lag as no other guidance was available.

Patients presenting with long-term conditions were referred on to their NHS GP after a conversation with the patient. Examples given were patients on medicine for high blood pressure or patients with diabetes. Sometimes patients were referred to local pharmacies where blood pressure could be checked. High risk medicines were not prescribed, except in a very limited emergency where supplies for of a few days would be issued. The test result would be requested from the patient to provide assurance that the medicine was required before a limited supply would be issued. An example of such a medicine includes those prescribed for thyroid disorders.

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. If the provider could not deal with the patient's request, this was explained to the patient and a record kept of the decision.

Quality improvement

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

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

The service monitored consultations and carried out consultation and prescribing audits to improve patient outcomes. We saw that 252 cases out of a total of 434 consultations were audited in March 2019. The results

showed good record keeping overall but that there was still room for improvement. The audit showed the provider was complying with guidelines for antibiotic prescribing. The provider had plans to re-audit.

Staff training

All staff completed induction training which consisted of safeguarding, information governance and fire safety. Staff also completed other training on a regular basis. The service manager had a training matrix which identified when training was due.

The GPs registered with the service received specific induction training prior to treating patients. An induction log was held in each staff file and signed off when completed. Supporting material was available, for example, how the IT system worked and aims of the consultation process. There was also a newsletter sent out when any organisational changes were made. 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.

Administration staff received regular performance reviews. All the GPs had to have received their own appraisals before being considered eligible at recruitment stage. The GPs had their own NHS appraisal system, but the provider was looking at doing internal appraisals for their GPs in the future rather than relying solely on NHS appraisals.

Coordinating patient care and information sharing

Before providing treatment, GPs at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history. The provider had access to the summary care record. We saw examples of patients being signposted to more suitable sources of treatment where this information was not available to ensure safe care and treatment.

All patients were asked for consent routinely to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service.

GPs entered the referral information onto the computer system when referrals were required including where the patient wanted to attend. There was a policy in place to check up on referrals to ensure these were received and processed including two week wait referrals. The two week wait policy specified for the medical director or registered manager in their absence to follow up on the referral. This had not been used as yet at the time of our inspection. The head office used this information to generate a referral letter to the patient's NHS GP which was sent to the patient. During the consultation permission was sought to share the patient's notes with their GP. The file was then sent to the practice using an NHS secure email address, verified by the administration team that the address was correct. The administration team called the GP to verify the patient was registered and looked up email addresses using the NHS database. If patients declined to share information with their GP this could be overridden if it was considered to be in the best interest of the patient. The provider used specific pharmacies to dispense the medicines and any patient counselling that was required. Feedback from the counselling was part of the signing off process by the pharmacy once the patient had obtained the medicine.

Supporting patients to live healthier lives

The service identified patients who may be in need of extra support and had a range of information available on the website (or links to NHS websites or blogs) for example smoking cessation and diet advice.

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

Good

Are services effective?

We rated effective as Good because:

Patients' needs were effectively assessed, and care and treatment were delivered in line with current legislation, standards and evidence-based guidance.

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

•The provider had risk assessed the treatments it offered.

Assessment and treatment

We reviewed 10 examples of medical records that demonstrated 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. Patients completed an online form which included their past medical history. There was a set template to complete for the consultation that included the reasons for the consultation and the outcome to be manually recorded, along with any notes about past medical history and diagnosis as they could access the summary care record (SCR). We reviewed 10 anonymised medical records which were complete records. We saw that adequate notes were recorded, and the GPs had access to all previous notes. However, we saw one example where no record of body mass index was recorded for oral contraceptives. There was no system to confirm that blood pressure had been checked by the pharmacist for oral contraceptives. This process was changed following the inspection and an alert was added to the system to highlight this.

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Good

Are services caring?

We rated caring as Good because:

The provider actively promoted the health of the population and feedback from patients was consistently positive about the service they received.

Compassion, dignity and respect

We were told that the GPs undertook online/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 with patients directly on the day of the inspection. However, we reviewed the latest survey information. At the end of every consultation, patients were sent an email asking for their feedback. Patients that responded indicated they were satisfied that the GPs were polite, made them feel at ease and they were listened to by the GP. Patients described the service as efficient, easy to use and professional.

Involvement in decisions about care and treatment

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

Patients had access to information about the GPs working for the service. Following our inspection, the provider changed their policy so that patients had the choice whether they wanted to consult with a male or female GP. The GPs available could speak a variety of languages and interpreters could be used for other languages.

The latest survey information available indicated that patients were satisfied with the explanation of their condition. The provider had received 163 responses back from patients. 94% of patients rated the provider as great or excellent, 4% as average and 2% as poor.

Patients could have a copy patients of consultation notes through their patient dashboard after their consultation.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

•The provider organised and delivered services to meet patients' needs, in a timely way.

•The provider's websites made clear what services were available

•The provider offered consultations to anyone over the age of 18 who requested and paid the appropriate fee and did not discriminate against any client group.

•Information about how to make a complaint was available on the service's web site.

Responding to and meeting patients' needs

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

Consultations were provided seven days a week, between 8.00am and 8.00pm, but access via the website to request a consultation was all day every day. 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 requested an online consultation with a GP and were contacted at the allotted time. The usual length of time for a consultation was 10 minutes. However, we were given examples of when patients had required some extra time.

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 or it was clear to patients that they could only use a dedicated pharmacy.

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.

At the time of inspection, patients were informed which GP they would have their consultation with, immediately after they booked their appointment via email. Following our inspection the provider implemented a feature where the patient could see the consulting GP details prior to booking.When a patient selected an appointment slot, a description of the GP was now provided. The patient then had the ability to request for additional preferences such as gender, language or clinical speciality. The patient support team would arrange for the consultation to be made considering the patients preferences.

Managing complaints

Information about how to make a complaint was available on the service's web site. The provider had developed a complaints policy and procedure. The policy contained appropriate timescales for dealing with the complaint. There was escalation guidance within the policy. A specific form for the recording of complaints had been developed and introduced for use. We reviewed the complaint system and noted that comments and complaints made to the service were recorded. We reviewed two complaints out of 11 received in the past 12 months. One complaint showed that a patient had made a request for a sick note. The circumstances of doing so were considered not to be appropriate and this was explained to the patient without a sick note being issued.

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

Consent to care and treatment

The website displayed the 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. The costs of any resulting prescription or medical certificate were handled by the administration team at the headquarters following the consultation.

The provider had risk assessed the treatments they offered. They had identified medicines that were not suitable for prescribing if the patient did not give their consent to share information with their GP, or they were not registered with a GP. For example, medicines liable to abuse or misuse, and those for the treatment of long-term conditions such as asthma. Where patients agreed to share their information, we saw evidence of letters sent to their registered GP in line with GMC guidance.

Good

Are services responsive to people's needs?

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.

Good

Are services well-led?

We rated well-led as Good because:

The service was led and managed effectively and drove the delivery and improvement of high-quality,person-centred care and leaders had a shared purpose.

•There was a clear organisational structure and staff were aware of their own roles and responsibilities.

•Patients could rate the service they received.

•The values of the service were to deal with patients in a sensitive and caring way.

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. We reviewed business plans that covered the next five years. The provider aimed to provide a safe, quality, affordable and accessible service. They wanted to be able to empower people to manage their own health in the best way possible.

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 annually and updated when necessary.

There was 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 from these checks was used to produce a clinical weekly team report that was discussed at weekly team 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.

Leadership, values and culture

There was a strong leadership from the Chief Executive Officer (CEO) supported by a leadership team of four, including medical, technological and sales expertise. The provider engaged with pharmacies in Coventry, which meant there was a feedback mechanism from a national network of pharmacies. The provider recently became members of the national committee set up by independent digital health providers, with the aim of sharing best practice and introducing safer, better care.

The provider acknowledged that one of the challenges was not enough patient feedback. They used a website for patients to leave reviews and had a good response rate. More recently they added a questionnaire for patients to complete which produced a greater quantity of results and patient feedback.

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

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

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

There were policies and IT systems in place to protect the storage and use of all patient information. The service could provide a clear audit trail of who had access to records and from where and when. The service was registered with the Information Commissioner's Office. 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 it fell below the provider's standards this would trigger a review of the consultation to address any shortfalls. In addition, patients were emailed at the end of each consultation with a link to a survey they could complete or could also post any comments or suggestions online. Patient feedback was published on the service's website.

There was evidence that the GPs could 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.

Good

Are services well-led?

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 registered manager 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 from minutes of staff meetings where previous interactions and consultations were discussed.

Staff told us that the team meetings were where they could raise concerns and discuss areas for improvement. We saw minutes of the monthly all staff meetings. However, as the management team and IT teams worked together at the headquarters there were always ongoing discussions about service provision.

There was a quality improvement strategy and plan in place to monitor quality and to make improvements, for example, through clinical audit. 252 cases out of a total of 434 consultations were audited. The proportion was so high as Clinical Guardian has streamlined the process. Of the 252 cases scored 5 were rated as Excellent, 213 as Good, 23 as Satisfactory, 9 for reflection, 2 for concern (slight). 20 cases were subject to group review. Copies of the Audit results have been emailed to the Doctors which includes global scores and comments from Group review. Following the audit it was decided this would be done on a quarterly basis to ensure a high quality of note-taking. The audit also showed that anti-biotic prescribing was in line with current guidelines.