ZoomDoc

Inspection report

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

Ratings

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

Overall summary

We rated this service as Good overall.

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 had inspected the service at another location in February 2018 using our previous methodology and had not applied a rating. We had identified some areas of non-compliance with regulations, relating to safe and effective care, including issues regarding the service's medicines and prescribing protocols, infection prevention and control audits and evidence of staff training. ZoomDoc Ltd (the provider) sent us a plan of the action it would take to address the issues and comply with the relevant regulations.

The provider had moved its business to the new location in January 2019. We carried out an announced comprehensive inspection on 10 September 2019 to follow up on the breach of regulations and to assess a rating for the service. We found that the provider had taken appropriate action to meet the requirements of the regulations.

The provider offers a private GP service, initially by telephone and online video consultations bookable via a secure mobile application (app.). GPs may visit patients at their homes, office or hotels, having triaged the patients' condition and healthcare needs, or if specifically requested by the patient. Patients can book a 10-minute telephone or online video consultation or a 25-minute face-to-face consultation with a GP 24 hours a day and seven days a week.

At this inspection we found:

- The provider had good systems to manage risk so that safety incidents were less likely to happen. There were processes in place to ensure when incidents did occur they were investigated and learned from.
- The provider routinely monitored the effectiveness and appropriateness of the service.
- Patients could access care and treatment from the provider within an appropriate timescale to meet their needs.
- Staff involved and treated people with compassion, kindness, dignity and respect.

The areas where the provider should make improvements are:

- Review the arrangements for holding regular clinical meetings with GPs, to ensure effective communication on matters relating to the service.
- Review the arrangements for conducting regular clinical audits to drive improvement.
- Continue to monitor prescribing within the service to ensure appropriate prescribing of broad-spectrum antibiotics.
- Maintain evidence of GPs' ongoing Mental Capacity Act training relating to patients' consent to treatment.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team comprised a CQC lead inspector and a GP specialist adviser.

Background to ZoomDoc

ZoomDoc Ltd (the provider) offers a private acute care GP service, initially by telephone and online video consultations bookable via a secure mobile application (app.). GPs may visit patients at their homes, office or hotels, having triaged and accessed the patients' condition and healthcare needs, or at the patients' request. Patients can book a 10-minute telephone or online video consultation or a 25-minute face-to-face visit with a GP 24 hours a day and seven days a week. Although telephone and online consultations are not limited geographically, most home visits are restricted to the London area, as many of the GPs are based there. However, a few of the GPs work in the Midlands. Patients can book appointments at a time to suit them with a doctor of their choice and must pay for a consultation by credit or debit card only via the ZoomDoc service app. Where appropriate, GPs may issue prescriptions, but this is only done following online video or face-to-face consultations, having checked and established the patient's identity. Notes of consultations are available for patients to access. The service is not intended to provide care in relation to patients' long-term health conditions. Patients requiring such care are referred to their own GPs. Nor is it an emergency service; patients with emergency healthcare needs are advised to call 999 or are directed to their local Accident and Emergency (A&E) department.

To be eligible to register for an account a patient must be aged 18 or over. Parents or legal guardians may later add children under 18 years old as patients to their primary service account after the initial registration. The provider told us around 6,500 people had registered as patients, of whom roughly 30% were children registered on their parents' primary accounts. The service has carried out 515 consultations since early 2018; of which 225 had been telephone consultations, 104 by online video and 186 visits had been conducted. At the time of the inspection there were on average five consultations per week.

The provider is registered by the Care Quality Commission under the Health and Social Care Act 2008 in respect of the regulated activities Transport services, triage and medical advice provided remotely and Treatment of disease, disorder or injury.

The provider does not directly employ any clinical staff. The Registered Manager is the lead GP, who undertakes patient consultations as part of the service, in addition to 28 self-employed GPs who operate as sub-contractors. We confirmed that all the GPs working in the service are registered with the General Medical Council (GMC) with a licence to practice and are on the GP Register. The GPs operate from home and so their opportunity to carry out visits to patients' homes is limited by distance.

Details of the service are available on the provider's website - www.zoomdoc.com

The provider has office space available at 29-30 Wakley Street London EC1V 7LT, but no clinical work takes place there.

How we inspected this service

Before the inspection we gathered and reviewed information from the provider. During the inspection we spoke with the lead GP, who carries out patient consultations and is also the Registered Manager. 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.

We reviewed the provider's governance policies and looked at eight sets of healthcare records of patients using the service. We did not speak with any patients or otherwise receive any direct feedback, but we did review feedback submitted by 16 patients via the service app. regarding their experience of 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.

Good

Are services safe?

At our previous inspection in February 2018, we found the service was not meeting the requirements of the regulations in providing safe services and served a requirement notice in relation to safe medicines management, processes relating to infection prevention and control and staff training records. At this inspection we found the service had addressed the issues we had identified previously.

We rated safe as Good because:

Keeping people safe and safeguarded from abuse

It was a requirement for the GPs registering to work with the service to provide evidence of up to date safeguarding training. We saw evidence that all had received adult and level three child safeguarding training. All GPs knew the signs of abuse, had access to the provider's safeguarding policies and where to report a safeguarding concern. The policies had been reviewed in early 2019, with the lead GP as the named responsible officer. GPs were required to record safeguarding team contact details specific to their working locations.

The service treated children and had a system in place to ensure that children were protected. Registered account holders could set-up profiles for children aged under 18, which could be viewed by the main account holder only. The provider had processes in place to ensure patients who included children on their accounts had parental responsibility for them and that evidence of parental responsibility be provided before a child could be seen by the visiting GP. The provider's policy on access to the records of patients aged 11-18 was in line with national guidance.

Monitoring health & safety and responding to risks

The GPs working in the service were self-employed and had to pass the provider's registration and vetting process before they were given access to the service's secure operating system. Patients did not attend the provider's business premises; the GPs carried out the telephone and online video consultations remotely and visited patients at their homes, offices or hotels.

The provider expected that all GPs would conduct consultations in private and maintain the patient's confidentiality. All GPs had been made aware of the provider's confidentiality policies, which had been reviewed in April 2019, as part of their induction and they had signed an online confidentiality agreement during their registration process.

The provider had a range of other up to date policies covering issues such as computer and data security procedure, a clear desk and screen policy, and email and internet usage policy to ensure the security of sensitive personal data. The GPs used an encrypted, password-protected smartphone which required fingerprint recognition to log on to their area of the service app. They could also access the operating system via a dedicated secure online portal, which was password-protected and required an access verification code. GP's accounts could be suspended immediately to prevent unauthorized access to the system, should their equipment be lost or stolen.

The service app. had a system failure protocol to ensure continuity of service. The provider had full and accessible data backups so that in the event of any system failure, data could be restored allowing normal operations to be resumed quickly and effectively.

There were processes in place to manage any emerging medical issues during a consultation and for managing referrals. The service issued referral letters for secondary care providers, including NHS and private hospitals and consultants if required.

The service was not intended for use by patients with either long term conditions or in emergencies. There were systems in place to ensure the location of the patient was known at the beginning of the consultation. The provider's emergency protocol stated patients should be advised to call 999 in an emergency. If the GP was in any doubt regarding the patient's ability to do so, or if the patient was alone, the GP would call 999 as the practitioner.

The provider made clear to patients what the limitations of the service were. The provider informed patients they were unable to prescribe high-risk medicines, including morphine-based medicines, strong sleeping tablets or medicines that would normally be prescribed (or require close monitoring) by a specialist. GPs themselves rated clinical consultations for risk and they could contact the lead GP to discuss any issues when necessary. There were processes in place regarding assessing and escalating risk.

Good

Are services safe?

At our previous inspection, we saw that the provider held quarterly virtual clinical meetings with GPs, where standing agenda items covered topics such as significant events, complaints and service issues. The meetings also included case reviews and clinical updates. However, at this inspection, we were told it had been difficult to maintain the programme due to GPs' work commitments outside the service and because of reduced service demand and business activity. The lead GP told us that a dedicated online networking platform had been set up so that service issues could be disseminated and discussed with the GP team. But we were not assured it was an appropriate alternative to formal regular clinical meetings.

The provider had various up to date policies covering such issues as lone working, health and safety, fire safety, needle stick injury, and infection prevention and control (IPC). We saw evidence that IPC checks and records relating to GPs' home visits had been introduced since our previous inspection and that these were monitored by the lead GP. The IPC policy had been reviewed in April 2019 and the lead GP was the named responsible officer. We saw that the provider now maintained a record of the training undertaken by GPs working in the service to ensure they were up to date in mandatory training such as health and safety and IPC. Evidence of this had not been available at our previous inspection. The record system alerted the provider when refresher training was due. This was monitored by the lead GP who informed the GPs accordingly. If training was not undertaken, the GPs would be suspended from working in the service until evidence was provided and recorded.

Staffing and Recruitment

There were enough GPs to meet the demands of the service. At the time of the inspection there were roughly five consultations a week. The GPs were paid on a per consultation basis. The lead GP was available to discuss concerns during consultations. The provider had arrangements for appropriate technical support over IT issues relating to the service.

The provider had an up to date recruitment policy and appropriate processes for selecting and appointing staff. Various steps were necessary prior to new staff being appointed, such as seeking two references and Disclosure and Barring Service (DBS) checks being undertaken. 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.

All GPs were self-employed. The provider stipulated that participating GPs must currently be registered with a licence to practice by the GMC and be on the GP register. They must also be working as a GP in the NHS. They were required to provide and up to date NHS appraisal and certificates relating to their qualifications and mandatory training subjects such as safeguarding, infection prevention and control and basic life support. Newly recruited GPs were supported during their induction period in accordance with a suitable induction plan. GPs did not start undertaking consultations until they had completed a face-to-face trial session with the lead GP and met all service requirements. The GPs' professional indemnity cover, including telephone, out of hours and call-out consultations, was arranged for by the provider, with evidence kept on the GPs' staff records.

We reviewed three sets of recruitment and employment records which showed the necessary documentation was maintained. The staff record system triggered alerts, which were monitored by the lead GP, when refresher training and insurance renewal became due.

Prescribing safety / safe use of medicines

At our previous inspection, we found the provider's protocols did not have clear guidelines on longer-term prescriptions of benzodiazepines (medicines used to treat symptoms of anxiety, panic attacks, insomnia and muscle spasms) without further investigation. The protocols allowed for prescribing oral contraceptive pill and hormone replacement therapy for up to six months, which was not in accordance with National Institute for Health and Care Excellence (NICE) guidelines. They did not include any information for GPs to guide when and which off license medicines they could prescribe, or provide safe storage guidance relating to Glucagon (an injection used to treat low blood sugar level) carried in the GPs' doctor's bags, which is affected when exposed to very hot or cold temperatures.

At this inspection, we found medicines prescribed to patients were monitored by the provider to ensure prescribing was appropriate and evidence-based. If a medicine was deemed necessary following a consultation,

the GPs issued private prescriptions to patients. The provider had up to date policies and prescribing protocols, in relation to telemedicine (phone and video consultations) and to home visits, which had been revised to address the issues we had identified at our previous inspection.

The GPs could only prescribe from a set list of medicines which the provider had risk-assessed. There were no controlled drugs on this list. The prescribing protocols contained clear guidance on medicines that could not be prescribed by GPs. These prohibited hypnotics and benzodiazepines, with the exception of diazepam for short term use for specific conditions. The protocols also made clear which medicines should not be initiated without a face-to-face consultation visit and physical examination of the patient. The prescribing policies stipulated the maximum length of prescriptions is two months for adults and one month for children, with some shorter length exceptions in relation to home visit prescriptions. The revised policies also stipulated that no off license medicines should be prescribed. Treating patients with off license medicines is higher risk than treating patients with licensed ones, because they may not have been assessed for safety, quality and efficacy for a condition not included in the license. The Medicine and Healthcare products Regulatory Agency (MHRA) guidance states that off license medicines may only be supplied against valid special clinical needs of an individual patient. The General Medical Council's prescribing guidance specifies that off license medicines may be necessary where there is no suitable licensed medicine.

The private prescriptions were written on headed paper, which included the provider's name, logo and other necessary information. The prescriptions were signed by the GP with their GMC number and contact number. The private prescriptions could be processed electronically via eFax. It was the prescribing GP's responsibility to liaise with the local pharmacy to ensure receipt of the faxed prescription and to post the original prescription to the pharmacy within 72 hours. All visiting GPs had access to a list of local pharmacies developed by the provider. Patients were able to choose a convenient pharmacy for dispensing their prescriptions. The prescriptions were only issued after an online video or face-to-face consultation, when the patient's identification had been verified. GPs gave patients relevant instructions to patients such as when and how to take the prescribed medicine, its purpose, any likely side effects and what they should do if they became unwell. When emergency supplies of medicines were prescribed, there was a clear record of the decisions made and the service contacted the patient's regular GP to advise them.

The service encouraged good antimicrobial stewardship by only prescribing from a limited list of antibiotics which was based on national guidance. GPs also had access to any local guidance relevant to where they were based. The lead GP monitored all prescribing and we reviewed the monitoring data. We saw some instances of inappropriate prescribing of broad-spectrum antibiotics, not being accordance with most local guidelines or national policy. We discussed this with the lead GP, who told us it had been noted and some GPs had been asked to review aspects of their antibiotics prescribing practice. We saw evidence of this in their appraisal records.

Each GP was responsible for the contents of their doctor's bag, used when attending home visits, including stock control and monitoring expiry dates of medicines. The provider's protocol and guidance had been revised since our last inspection, with Glucagon no longer being included in the list of suggested medicines carried in the bags, but with suitable alternatives proposed. The GPs used a standard check list to monitor the contents of their bags on a regular basis.

Information to deliver safe care and treatment

When patients registered to use the service there were processes in place to verify their identity using their mobile telephone numbers, email addresses and credit card details. Before a telephone consultation could be commenced GPs verified the patient's mobile telephone number which had been registered for the account. At each online video or face-to-face consultation, unless they were known to GPs previously, patients were required to confirm their identity using photographic evidence such as their passports or driving licenses. Patients could register their children on the main account. Patients were informed when registering for the service and when booking an appointment that the consultation would be declined if they failed to confirm their identity or evidence of parental responsibility, when the patient being seen was a child, before the start of the consultation. GPs made a record of the evidence produced in the notes of the consultation.

We reviewed eight sets of patients' care records and noted they were written and managed in a way that kept patients

Good

Are services safe?

safe. Patient records were stored securely using an electronic record system. The GPs could access the patients' previous service records using a doctor's app on their smartphones or via the doctor's portal on the service website. Both methods were secure, requiring authenticated log ins. The provider was registered with the Information Commissioner's Office. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way. Risks related to patients' diagnoses and other health and wellbeing risks were recorded in patients' records.

Management and learning from safety incidents and alerts

The provider had systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. The relevant protocol had been reviewed in April 2019 and there was an online significant event record form for GPs to complete and submit to the provider for review by the lead GP. The protocol stated that incidents and significant events would be discussed at clinical meetings and reviewed again within 3 – 6 months following resolution of the issue. However, we could not fully assess the effectiveness of the process as there had been no incidents to report and the convening of clinical meetings had lapsed.

The provider had a Being Open protocol, reviewed in April 2019, and another relating to the duty of candour, covering a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. The lead GP demonstrated an understanding of which incidents were notifiable under the duty of candour.

The provider received patient and medicine safety alerts issued by the NHS Central Alerting system and had set up a process for reviewing and disseminating those relevant to the service to the GP team.

Good

Are services effective?

At our previous inspection in February 2018, we found the service was not meeting the requirements of the regulations in providing effective services and served a requirement notice in relation to effective medicines management and staff training records. At this inspection we found the service had addressed most of the issues we had identified previously.

We rated effective as Good because:

Assessment and treatment

At our previous inspection we found the provider had not given clear clinical evidence-based guidance to prescribe longer prescriptions of benzodiazepines, the oral contraceptive pill and hormone replacement therapy which could lead to large quantities being prescribed without further investigation.

At this inspection, we reviewed eight sets 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. The provider had revised its prescribing protocols since our last inspection. These now stipulated that hypnotics and benzodiazepines, with the exception of diazepam for short term use for specific conditions, should not be prescribed by GPs in the service and all adult prescriptions should have a maximum length of two months.

When patients registered for the service they were required to complete a personal profile. This recorded information such as their past medical history, personal details, date of birth, drug allergies and their NHS GP details, together with consent to update the NHS GP on all consultation details.

The service offered telephone and face-to-face consultations, either by online video or home visits. We were told that each telephone consultation lasted for 10 minutes and each face-to-face consultation lasted for 25 minutes. If the GP had not reached a satisfactory conclusion there was a system in place where they could charge an additional fee for each additional five minutes required to make a full assessment of the patient's needs. Before visiting a patient, the GP would call to carry out an initial assessment by telephone. This was used as a triage process to ensure the service was suitable to meet the clinical needs of the patient. The system used a standard template to record details of the consultation, including the reasons for the consultation and the outcome, along with any notes about past medical history and diagnosis.

The GPs were aware of both the strengths of working as visiting GPs, for example speed, convenience, choice of time, and the limitations such as the inability to perform physical intimate examination due to a chaperone not being available. 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 took part in some quality improvement activity, such as an ongoing review of all patient consultations, and by each GP working in the service, recording the diagnoses and any prescriptions issued. However, there was no formal clinical audit programme in place.

The service has carried out 515 consultations since early 2018; of which 225 had been telephone consultations, 104 by video and 186 visits had been conducted. These included "upgrades", where following an initial phone call, 17 consultations had been changed to a visit to allow the GPs to fully assess the patients' healthcare needs; two cases were phone calls had been changed to online video consultations; and three online video consultations that had been changed to face-to-face visits. Records showed that 195 prescriptions had been given to patients following the consultations. The lead GP reviewed all the consultations and a sample were discussed with each GP as part of their regular performance reviews. The lead GP told us this had led to discussion with some of the GPs regarding their anti-biotic prescribing.

No formal prescribing audits had been conducted to monitor GPs' individual prescribing decisions. However, individual patients on prescribed medicines were monitored to identify the appropriateness of their medicines and overall clinical outcomes for patients were monitored. At our previous inspection, the lead GP showed us an outline clinical audit programme for 2018, but this process had not been implemented due to the low service take up since then.

Staff training

The GPs registered with the service had to receive specific induction training prior to treating patients. An induction log was maintained in the staffing records and signed off when completed. All GPs had to complete video training to

enable them to operate the service software. Supporting protocols were available as guidance on computer and data security procedures, information about how the IT system worked, and information about accessing patient records and the clinical notes recording process. When the IT system was updated, GPs were provided with guidance and received further online training.

The GPs had been given role-specific training and the provider had a monitoring system in place which identified when training was due. We reviewed three training records for GPs, which showed they were up to date in mandatory training, for example safeguarding vulnerable adults and child protection and basic life support. The records also contained evidence of GPs' ongoing training on infection prevention and control and information governance, which had not been maintained at our previous inspection. However, the records did not provide evidence that the GPs had up to date training relating specifically to the Mental Capacity Act (MCA) and patients' capacity to consent to treatment, an omission we had noted at our previous inspection. The lead GP said the information regarding GPs' mandatory NHS MCA training was collected when they joined the service, but evidence of it was not retained on their staff records. Following the inspection, the provider confirmed it had amended its requirements and would request and retain MCA training certificates henceforth. The GPs received regular performance reviews which were documented on their staff records.

Coordinating patient care and information sharing

When patients opened a service account the provider asked for consent to share details of their consultations with their NHS GPs. If the patients did not agree to this, but urgent healthcare issues were identified at the consultation, the GPs would discuss sharing information with them again to seek consent. We were told that if patients agreed at that time correspondence would be sent to their registered GP in line with GMC guidance. We saw two examples where patients had given consent for consultation notes being shared with their NHS GP and one instance of notes being shared. If a patient's healthcare issues required further investigation, they were signposted to their own GP or to their nearest A&E department, or the provider could refer them to a range of private consultants. The provider monitored referrals to ensure they were clinically appropriate. Correspondence was shared with external professionals in a way that ensured data was protected. Information systems required passwords in order to access any data shared with external healthcare providers. The provider had a teenager confidentiality policy. After consultations with teenagers, encrypted clinical notes or referral letters were added to the main service account record with the patient's consent.

The provider did not arrange diagnostic tests directly. In cases where the GPs conducted a consultation and concluded the patient's symptoms required further investigation, they would refer them to an appropriate alternative agency.

Supporting patients to live healthier lives

The GPs provided patients with lifestyle advice appropriate to their needs. The service identified patients who may be in need of extra support and provided links to websites which contained helpful information or signpost to the relevant agency or provider.

Good

Are services caring?

We rated caring as Good because:

Compassion, dignity and respect

The provider instructed GPs to conduct telephone and video consultations in a private room, where they would not be disturbed, and patients were advised to do the same to protect their privacy. The provider carried out random performance reviews to ensure the GPs were complying with the expected service standards and communicating appropriately with patients. Feedback arising from these performance reviews was relayed to the GP. Any areas of 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. The service was not registered with any online review websites, but the service app. was designed to request feedback at the end of every consultation. We reviewed feedback provided by 16 patients, which was consistently positive regarding all aspects of the service.

Involvement in decisions about care and treatment

Patient information guides about how to use the service and technical issues were available and the lead GP responded to any enquiries.

Patients had access to information about the GPs working for the service and could book a consultation with a GP of their choice. For example, whether they wanted to see a male or female GP. The service app. showed patients where the nearest on duty GP was operating.

We reviewed eight examples of medical records and found they were personalised and patient-specific indicating patients were involved in decisions about care and treatment. The feedback we reviewed was also positive regarding this aspect of care.

The 28 GPs currently working in the service had a range of languages in addition to English, allowing patients a further element of choice. The lead GP told us that a telephone interpreter service was available if needed, but this had not been necessary as patients usually attended consultations with an English-speaking relative or friend.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

Responding to and meeting patients' needs

Patients could request a telephone or online video consultation, which was offered nationwide, or a face-to-face consultation by GPs' visit, mostly limited to in and around London, with a GP via the provider's app. The GPs logged into the service system when available to work and patients could see from the service app. which GPs were located nearby. They could request an appointment with a specific GP and choose a convenient time slot. When making the request, the patient provided a short summary of their symptoms, which was then passed on to the GP of their choice.

The service provided medical assessments, clinical examination, diagnoses, prescriptions and referral letters for private hospitals or private consultants. Sick notes could be supplied if required. Patients could register and access the service using a smartphone or tablet computer, using iPhone or Android operating systems. The service offered flexible appointments at all times and could be booked to meet the needs of their patients. This service was not intended for emergency use. Patients who had a medical emergency were advised to ask for immediate medical help via 999 or attending A&E, or if appropriate to contact their own GP or NHS 111. The provider's protocol stated that where GPs had concerns for a patient's wellbeing in an emergency they should call 999 as practitioners.

Patients could book consultations for a set fee. The telephone and video consultations lasted 10 minutes, while visits were 25 minutes. However, we were told that GPs might extend the consultations at additional cost if they had not been able to make an adequate assessment or provide treatment. The consultation fees were set out on the provider's website and made clear to patients via the service app. when booking. There were standard charges that applied on Monday to Friday, 8.00 am to 6.00 pm, which increased slightly during evenings, weekends and bank holidays. The service terms and conditions were also included on the provider's website.

Patients were able to contact the service free of charge within 24 hours of the consultation to discuss any concerns. Patients were able to discuss their care with any on-call GP or request to speak to the GP who had conducted the consultation. If the same GP was not available then patients were able to set an alert via the service app for a call back, to ensure the continuity of quality care.

The provider's app allowed people to contact the service from abroad. All GPs working in the service were required to be based within the United Kingdom and registered appropriately with the GMC.

The provider made it clear to patients what the limitations of the service were. For example, the private prescriptions were only issued by the visiting doctor after a video or face to face consultation, when the patient's identity had been confirmed. The prescriptions could be processed electronically via eFax to a local pharmacy of the patient's choice or written on the provider's headed paper.

Tackling inequity and promoting equality

The provider offered consultations to anyone who requested one and who had paid the appropriate fee and it did not discriminate against any client group. Patients could access a brief description of the GPs currently available. Patients could choose either a male or female GP or one who spoke a particular language or had a specific qualification or specialism.

Managing complaints

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 which included the complainant's right to escalate the complaint to the Independent Healthcare Sector Complaints Adjudication Service (ISCAS) if dissatisfied with the response. Information about how to make a complaint was available on the service app. but not referred to on the provider's website.

We reviewed the provider's complaints process. Three patients had submitted a complaint in the past 12 months, none of which related to clinical issues. We reviewed each one and found they had been dealt with speedily and effectively, with patients being given a satisfactory response. We saw evidence that the provider had given the patients an honest explanation and an apology, and fully or partially refunded the fees charged. The provider used the information in ongoing service monitoring.

Consent to care and treatment

Good

Are services responsive to people's needs?

The provider had policies in place relating to patients' consent to treatment. These had last been reviewed in April 2019 and covered for example, children's consent in accordance with the Gillick principals – designed to assess and establish a child's capacity to consent – and the Mental Capacity Act (MCA). The provider required GPs to seek patients' consent to care and treatment in line with legislation and guidance. However, the provider was not able to show us evidence that GPs had received up to date MCA training. 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.

There was clear information on the provider's website and within the service app. setting out how the service worked, and the costs involved. It included a set of frequently asked questions providing additional guidance and contact details for service enquiries.

Patients were able to make informed choices; the cost of the consultation was known and paid for in advance. Any additional costs, such as a prescription fee, the cost of medicines dispensed from the doctor's bag, extended consultation time necessary to establish the full facts, referral letters or medical certificates, were added to the bill following the consultation and documented in the patient's notes. All payments were made using the credit or debit card details saved on the system when the patients had set up their service accounts.

Good

Are services well-led?

We rated well-led as Good because:

Business Strategy and Governance arrangements

The provider had a clear vision to develop the business in order to provide a high-quality responsive service that put caring and patient safety at its heart. Its aim and objectives were set out in its statement of purpose. There were business plans that included the expansion of the services provided. There was a range of service-specific policies, which all GPs were required to comply with, and these were reviewed on an annual basis, being updated when necessary. GPs were informed of the reviews and were required to acquaint themselves with the policies. There was a clear organisational structure and staff were aware of their own roles and responsibilities.

There were various regular checks in place to monitor the performance of the service, including monitoring all consultations and prescribing and scheduled and random reviews of GPs' consultations. However, the provider had not implemented a formal a system of regular clinical audit to assess, monitor and improve the quality of the service, which had been planned at our previous inspection. Care and treatment records were complete, accurate, and securely kept.

There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. Remedial action had been taken relating to most of the issues identified at our previous inspection.

Leadership, values and culture

The lead GP, who was a founder and chief executive of the provider, was the Registered Manager. The lead GP worked daily within the service and had overall responsibility for any medical issues relating to the service provision. There were systems in place to cover the lead GP's absence. There were adequate staffing arrangements to meet current service demands and capacity and plans to increase staffing as the business developed.

The service had an open and transparent culture. We were told that if there were unexpected or unintended safety incidents, the provider would give affected patients reasonable support, truthful information and a verbal and written apology. This was supported by up to date operational policies, covering the Duty of Candour and "Being Open".

Safety and Security of Patient Information

Systems were in place to ensure that all patient information was stored and kept confidential. The provider had a range of policies relating to confidentiality and information governance and there were strict arrangements to protect the security of all patient information. Systems had been established that restricted unauthorised access to records. The provider was registered with the Information Commissioner's Office. There were system failure procedures relating to the service app and IT system and data security procedures operated to minimise the risk of losing patient data. The provider had arrangements in place to ensure that patient records could be retained for the required length of time should it cease to trade.

Seeking and acting on feedback from patients and staff

The service app. allowed patients to rate their experience after each consultation and provide feedback. However, the lead GP told us this feature had been malfunctioning recently and remedial action had been taken. The ratings and feedback were monitored by the lead GP and, if negative, triggered a review of the consultation to address any shortfalls. Patients' ratings were for individual GPs appeared next to the GPs' profile on the service app. screen.

Patients were encouraged to submit their views and concerns after each consultation, which the provider acted on to improve the service. For example, technical changes had been made to the service app. following feedback. Staff were able to provide feedback and suggest changes and improvements at their performance reviews and via a dedicated online networking platform set up by the provider. The provider had previously had quarterly clinical meetings, operated by video conferencing. But these had proved to be difficult maintain due to the GPs' work commitments outside the service and because of current low service demand. The networking platform had replaced the meetings as a means of sharing information, peer support and to monitor the service and resources, but we were not assured it was an appropriate alternative. All GPs had had their annual service appraisal which was conducted by the lead GP and we saw examples of appraisal forms where GPs had given feedback on service issues.

Good

Are services well-led?

The provider had introduced a whistleblowing policy since our last inspection, with the lead GP being the named responsible officer. A whistle-blower is someone who can raise concerns about practice or staff within the organisation.

Continuous Improvement

There was a focus on continuous learning and improvement at all levels within the service.

GPs could raise concerns and discuss areas of improvement with the clinical lead as and when required. All GPs were encouraged to identify opportunities to improve the service delivered and to participate in ongoing discussions and exchanges via the online networking platform. The lead GP told us of plans to expand the scope of the service and that business negotiations were ongoing.