iPrimary Care Limited

iPrimary Care Head Office

Inspection report

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Date of inspection visit: 25 July 2017
Date of publication: 18/09/2017

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at iPrimary Care Limited on 25 July 2017.

iPrimary Care Limited provides online medical services, including prescribing services, through its website www.valahealth.com. Patients can request a GP consultation for assessment, diagnosis and management of non-urgent primary health care problems. The provider's stated aim is to focus on healthy lifestyle, wellness and prevention, not just acute management of illness or injury.

We found this service provided safe, effective, caring, responsive and well led services in accordance with the relevant regulations.

Our key findings were:

- The service had clear systems to keep people safe and safeguarded from abuse.
- There was a comprehensive system in place to check the patient's identity.
- There were systems in place to mitigate safety risks including analysing and learning from significant events and safeguarding.
- There were appropriate recruitment checks in place for all staff.
- We found patients being prescribed a range of medicines and these had been assessed to ensure they were safe to provide through an online service.
- There were systems to ensure staff had the information they needed to deliver safe care and treatment to patients. Staff were aware of and kept up to date with National Institute for Health and Care Excellence (NICE) guidance and medical alerts.
- The service learned and made improvements when things went wrong. The provider was aware of and complied with the requirements of the Duty of Candour.
- Patients were treated in line with best practice guidance and appropriate medical records were maintained.
- The service had a programme of ongoing quality improvement activity.
- An induction programme was in place for GPs. Staff, including GPs, also had access to all policies online.
- The service shared information about treatment with the patient's own GP if the patient gave consent.
- Survey information we reviewed showed that 13 of the 14 patients who responded said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints. There was a clear business strategy and plans in place.
- Staff we spoke with were aware of the organisational ethos and philosophy.
- There were clinical governance systems and processes in place to ensure the quality of service provision.

Summary of findings

- The service encouraged and acted on feedback from both patients and staff.
- Systems were in place to protect personal information about patients.

We saw the following area of notable practice:

- The service followed up all patients post consultation/ treatment via email, to ensure they had no concerns or had suffered any side effects.

The areas where the provider should make improvements are:

- Maintain a record of recruitment interviews.
- Have a system in place to automatically flag up potential multiple log-ins from the same patient.
- Review and simplify the process to recall archived notes.

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

- All staff had received safeguarding training appropriate for their role. All staff had access to local authority information if safeguarding referrals were necessary.
- Patient identity was checked on registration and at every consultation or when prescriptions were issued. All patients had to provide photo identification. A service was provided to children however they could not access the service without being accompanied by a responsible adult.
- There was just one GP at the time of the inspection. The provider felt that this was sufficient to meet the current demand of the service and appropriate recruitment checks for all staff were in place.
- 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 continuity plan.
- Prescribing was constantly monitored and all consultations were monitored for any risks.
- There were systems in place to respond to patient risk.
- 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 was an effective system to deal with safety alerts such as those issued by the Medicines and Healthcare products Regulatory Agency (MHRA).

Are services effective?

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

- The 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 a programme of ongoing quality improvement activity. For example we were provided with two completed audits which had resulted in reduced prescribing risks to patients.
- There were induction, training, monitoring and appraisal arrangements in place to ensure staff had the skills, knowledge and competence to deliver effective care and treatment. The provider had devised its own online training videos specifically for online digital services.
- The service had arrangements in place to coordinate care and share information appropriately for example, when patients were referred to other services.
- The service's web site contained information to help support patients lead healthier lives, and information on healthy living was provided in consultations as appropriate.

Are services caring?

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

- We were told that the GP undertook consultations remotely, and the service expected them to conduct consultations in an appropriately private setting.

Summary of findings

- We did not speak to patients directly on the day of the inspection; however, we reviewed the latest survey information. The provider received scores of between three and five (out of five) for the service it provided. Thirteen of the 14 patients who responded scored the service five when asked if they would recommend them to friends and family. At the end of every consultation, patients were sent an email asking for their feedback.

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.
- The website was available 24 hours a day, seven days a week. GP consultations were generally available between 7am and 7pm Monday to Friday; and between 7am and 12pm on Saturday and Sunday.
- Patients requested an online consultation with a clinician and were contacted at the allotted time. Consultations were scheduled to last 30 minutes, but this could be extended if necessary.
- Information about how to make a complaint was available on the service's web site. The provider was able to demonstrate that the complaints we reviewed were handled correctly and patients received a satisfactory response.
- Consent to care and treatment was sought in line with the provider policy. The GP had received training about the Mental Capacity Act.

Are services well-led?

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

- 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.
- 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.
- Systems were in place to ensure that all patient information was stored securely and kept confidential. 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.
- The service consistently sought ways to improve. It had developed its own online training modules specifically for digital care providers. It was looking at ways to enhance patient identification so as to reduce risk.

iPrimary Care Head Office

Detailed findings

Background to this inspection

iPrimary Care Limited provides a range of internet based health and wellbeing services direct to patients in the form of online health consultations, health advice and the issuing of private prescriptions. Patients can book a consultation with doctors, physician associates (physician associates work under the direct supervision of a doctor and carry out many similar tasks, including patient examination, diagnosis and treatment), physiotherapists, dietitians, psychotherapists and fitness trainers. The provider offers these services to individuals or to businesses. Businesses can opt to provide their employees with an annual budget to use in a way that best suits their needs and the business.The majority of the provider's clients are currently through corporate contracts.

Their website advertises a range of services relating to women's health; men's health; travel; mental health; general health; sexual health; diet and nutrition; physical fitness and children's health. Patients can opt for a one off consultation or sign up to a monthly or annual plan. They do not have clinical premises where patients can visit.

GP consultations are generally available between 7am and 7pm Monday to Friday; and between 7am and 12pm on Saturday and Sunday. Services are provided to children however we were given assurances that any patients under the age of 18 years would need a parent or legal guardian to request a consultation and set up the user specific remote access. This access is then password protected to prevent unauthorised use. All initial GP consultations are carried out by video link, however subsequent consultations can be by telephone.

At the time of this inspection the registered manager role was shared between two of the company founders, although they planned to change this to just one registered manager in the near future. 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.

Operational activities are managed and undertaken by the GP (who was also the medical director and one of the registered managers), a physician associate (the other registered manager) and a (non-clinical) chief executive officer.

How we inspected this service

Our inspection team was led by a CQC Lead Inspector accompanied by a GP specialist advisor and a member of the CQC medicines team.

Before visiting, we reviewed a range of information we hold about the service and pre inspection information provided by iPrimary Care Ltd.

During our visit we:

- Spoke with the three staff currently operating the GP consultation service.
- Reviewed organisational documents, such as policies and procedures and other documentation which the provider held in relation to the provision of services.
- Reviewed staff records.
- Reviewed a sample of patient consultation 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?

Detailed findings

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 (Regulated Activities) Regulations 2014.

Are services safe?

Our findings

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

Keeping people safe and safeguarded from abuse

Staff employed at the headquarters had received training in safeguarding and whistleblowing and knew the signs of abuse and to whom to report them. The current GP had received level three child safeguarding training and adult safeguarding training. It was a requirement for any GP 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. The service had identified the difficulties in trying to maintain a countrywide overview of safeguarding lead authorities but nevertheless had created links within their safeguarding procedure to each local authority. The policy contained the specific contact details of the safeguarding authority in the local authority in which they were based.

The service treated children of any age. Safeguards were in place to prevent anyone under the age of 18 accessing the service unless accompanied by either a parent or someone with parental responsibility. The adult requesting the service would have to show photographic identification for themselves and the child they wished to have treated. Once an account had been set up it was password protected, with the password being shared with the adult only. If a child tried to access the service they would be asked to show photographic identification, which would confirm their age, and, if under 16, prevent further access.

Monitoring health & safety and responding to risks

Monthly clinical meetings were held, during which staff reviewed any adverse events, complaints and patient feedback. The meeting minutes supplied to us prior to the inspection evidenced this.

The GP told us that they reviewed treatment requests for risk as part of consultations and if there were any concerns further information would be requested from the patient or treatment would be refused. We saw evidence where an initial enquiry about prescribing was not progressed to a consultation because the doctor felt the potential risk was too great. For example, they had received a query regarding prescribing contraception to a minor. The GP reviewed this request and decided that the possible risks were unacceptable, and the query was not progressed.

The provider headquarters was located within purpose built offices, housing the IT system, management and associated IT company. Patients were not treated on the premises and the GP carried out the online consultations remotely. Staff had received training in health and safety including fire safety. There was a business continuity plan in place.

The provider expected that all GPs would conduct consultations in private and maintain the patient's confidentiality. The GP used their laptop to log into the operating system, which was a secure programme. The service did not have a system in place to automatically flag up potential multiple log-ins from the same patient. They could carry this out through an audit to identify similar names, addresses, email and/or phone numbers, and after we flagged this as a potential risk during the inspection the provider stated that as they expanded patient numbers, this was something they would seek to build into their software.

There were processes in place to manage any emerging medical issues during a consultation and for managing test results and referrals. All test results were reviewed by the GP then shared with the patient. If a referral was required the service would make the necessary arrangements with the patient's local GP or specialist and keep the patient up to date on progress.

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. The service informed patients that it was mandatory for them to provide their address, phone number and current whereabouts not only so that they could be located if there was a medical emergency but also to ensure the patient was in an appropriate setting for the consultation to be carried out.

Are services safe?

As the provider called the patient for their appointment, they had not had to deal with any issues regarding withheld numbers. Patients made an initial appointment online. The service then confirmed this by email and then contacted the patient at the appropriate time.

Staffing and Recruitment

At the time of this inspection operational activities were managed and undertaken by one GP (who was also the medical director), a physician associate (physician associates work under the direct supervision of a doctor and carry out many similar tasks, including patient examination, diagnosis and treatment) and a (non clinical) chief executive officer. The provider told us that they felt there were sufficient staff to meet the current demand of the service. This minimal staffing level did mean, however, that there were periods, sometimes weeks, when a GP consulting service could not be provided. The provider told us that in these circumstances patients were given advance warning and notices were put on their website. To date, they said they had not received any adverse comments or complaints about this.

The provider had a selection process in place for the recruitment of all staff. Required recruitment checks were carried out for all staff prior to commencing employment. Potential GP candidates had to be registered with the General Medical Council (GMC), on the GMC GP register, be on the performers list and based in the UK and have had their appraisal. Those GP candidates that met the specifications of the service then had to provide documents including proof of registration with the GMC (and other professional bodies), proof of their qualifications and certificates for training in safeguarding. The provider had group medical indemnity in place, which provided appropriate cover for the remote service.

We reviewed two recruitment files which showed the necessary documentation had been requested and was available. The GPs could not be registered to start any consultations until these checks and induction training had been completed. Induction for clinical staff was carried out by the medical director. The provider kept records for all staff including the GP. We noted these records did not include transcripts of recruitment interviews.

Prescribing safety

Medicines prescribed to patients were monitored by the provider to ensure prescribing was appropriate. We saw that three separate prescribing audits and two external reviews had been carried out. If a medicine was clinically appropriate following a request, the GP was able to issue a private prescription to patients. We found that the provider did have a method of confirming the identity or age of the patient, which had been introduced following a review of their previous process.

The GP was able to prescribe medicines contained within the British National Formulary and the provider reviewed and restricted the medicines available in a proactive manner. The service no longer prescribed any controlled drugs. Where medicines were prescribed to be taken outside of the manufacturers marketing authority there was a clear record that this had been discussed with the patient and their consent to this treatment was recorded.

We looked at a sample of six patient records. We saw that there was a contemporaneous record of prescriptions requested, declined and supplied. The practice showed us evidence that when prescribing was possibly not safe they did not prescribe with the reasons given to the (potential) patient.

We saw that when prescribing the GP sought details of the patient's usual health care professional and sought permission to share information with them. When this happened although a record was made it was not always straightforward to access this information. Patients were encouraged to let the service contact the GP and evidence was seen where this was happening.

When a decision to prescribe was made a prescription was issued and this was either forwarded to the patient for them to take to the pharmacy of their choice or the provider could send the prescription to the patient's preferred pharmacy.

Information to deliver safe care and treatment

On registering with the service, and at each consultation patient identity was verified, initially by photographic ID, then by personal details and password; and the GPs had access to the patient's previous records held by the service. The provider had also taken the step of meeting all of the patients to whom they provided a service. The provider was aware of the potential risks of remotely identifying someone, and was in the process of reviewing how they could further reduce this risk.

Are services safe?

Management and learning from safety incidents and alerts

There were systems in place for identifying, investigating and learning from incidents. We reviewed the significant event register, which had four entries, and found these had been fully investigated, discussed and as a result action taken in the form of a change in processes. For example: in response to an issue regarding the cost of a blood test, the provider refreshed clinicians' knowledge of the pricing structure, and also ensured that the patient was given a full explanation and appropriate refund. Outcomes and learning from significant events was shared with staff via the provider's intranet system. Staff could access online reporting forms.

Staff were aware of the requirements of the Duty of Candour and confirmed that if an incident occurred they would explain to the patient what went wrong, offer an apology if appropriate and advise the patient of any action taken. A policy relating to duty of candour was in place for staff to follow.

We asked the provider how patient safety alerts were dealt with such as those issued by the Medicines and Healthcare products Regulatory Agency (MHRA). The GP was able to demonstrate how he kept up to date by using a mobile phone app to receive the alerts and he was fully aware of a drug safety alert which had been issued a few days before the inspection, although it was not relevant to any of their patients. There were records made to record that alerts had been actioned and there was a process within the organisation to review patients who may have been prescribed medicines which were the subject of these alerts. Alerts were also flagged up on the provider's intranet system and shared through their blog.

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.

Assessment and treatment

We reviewed five examples of medical records that demonstrated that the 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 saw that adequate clinical notes were recorded, although a record of discussions with patients about background information was not always recorded. The GPs had access to all previous notes albeit it was not a straightforward or simple process to recall archived notes. The provider commented that they would review and simplify this process in light of the inspection findings. Following the inspection, as part of the factual accuracy process, the provider informed us that their IT systems had been updated to simplify the recall process giving them full access to archived notes from the patient search function.

We were told that each initial consultation lasted for 30 minutes. If the GP had not reached a satisfactory conclusion they told us they would extend the consultation, and an additional fee would be requested. The service emailed each patient post treatment to follow up how effective the treatment had been, if there had been any side effects and to check on the patient's general well-being.

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.

The GP providing the service was 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.

Quality improvement

The service monitored consultations and carried out consultation and prescribing audits to improve patient outcomes. We saw that they had carried out three audits relating to controlled drugs, antibiotics and contraception. One audit cycle had been carried out on contraceptive prescribing however four cycles had been carried out with regard to the audits of controlled drugs and antibiotics. The initial audit of prescribing of controlled drugs showed that contrary to the service's policy, there had been four prescriptions issued for these drugs. Even though this was not in line with the iPrimary Care policy, the service considered that all of the prescribing appeared safe. As a result, the service decided to amend its policy to allow short courses of some controlled drugs. This amendment was then reviewed with a second audit. This audit indicated there had been five prescriptions issued, one of which the reviewer felt was inappropriate. The service subsequently amended its prescribing policy to state that no controlled drugs would be prescribed by iPrimary Care clinicians as they felt the potential risk to be unacceptable. A third audit cycle showed there had not been any further prescribing of these medicines.

Staff training

All clinical staff had to complete induction training. This was carried out by the medical director and included an outline of the service vision; roles and responsibilities; safeguarding; what to do in emergencies; patient follow up and confidentiality. New staff also had to complete the service's online training sessions. These included video consultations; online emergencies; online prescribing and confidentiality and Caldicott. When updates were made to the IT systems, the GPs received further online training.

All staff had access to the services' online policies and procedures. If any organisational changes were made this was communicated to staff via its intranet. We accessed the intranet system and found it provided staff with clear and simple guidance on how to navigate around the system and access, for example, policies, procedures, good practice guidance and the minutes of (in-house) clinical meetings.

GPs were expected to receive appraisals externally, whilst other staff, including the physician associate, received supervision and an annual appraisal from the medical director.

Coordinating patient care and information sharing

Are services effective?

(for example, treatment is effective)

When a patient contacted the service they were asked if the details of their consultation could be shared with their registered GP. If patients agreed we were told that a letter was sent to their registered GP in line with GMC guidance, and copied to the patient. We saw evidence to support this. Patients were not required to provide this information in order to receive treatment.

Patients could access a 'patient timeline' once they had registered and undergone their first consultation. Patients were able to add their own information to this timeline, such as allergies or details about previous vaccinations for example. Within the consultation record we saw patients could access a summary from the GP, details of their treatment, where to get their prescriptions, and any possible side effects of medicines prescribed. Any subsequent consultations were added to this record, so the patient always had full access to their record.

Test results were reviewed by the GP and then discussed with the patient. Whilst we found that results were reviewed promptly, there was little in the way of a safety net should the GP be unavailable. The provider felt that this did not present an issue currently, given the small number of patients; however they acknowledged that as the service expanded they would need to review their processes to ensure test results were always reviewed without delay. We saw that test results had been promptly checked and appropriately actioned.

Supporting patients to live healthier lives

The provider's website highlighted that the philosophy of the service was that healthcare should be 'member-directed', integrated with their whole life, and focused on optimising health. Alongside a GP consultation service patients could also access, for example, dieticians, fitness trainers, psychotherapists and physiotherapists.To access these services patients registered and then when making an appointment selected which practitioner they wished to consult with.

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 GP undertook consultations remotely, and the service expected them to conduct the consultations in an appropriately private setting. At the time of this inspection the provider had not yet carried out random spot checks to ensure the GP was complying with the expected service standards and communicating appropriately with patients, however this was because the service had just one GP currently, who was also the medical director. Data transmitted to and from the provider's website was encrypted to add security.

The provider carried out patient surveys and results were analysed and discussed at regular meetings. A procedure was in place to monitor and respond to patient feedback including complaints, significant events, feedback following patient consultations and patient surveys.

We did not speak to patients directly on the days 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. This feedback was collated and reviewed at regular clinical meetings. Where changes were made, or action taken as a result of the feedback, this was recorded. For example, a patient fedback that they had received an error message when trying to access an appointment. It transpired that the patient was using another patient's account, and that patient had disclosed the password. The service contacted both patients and reiterated the need not to share passwords or account details. The service was reassured that their systems had picked up and prevented this unauthorised access.

Involvement in decisions about care and treatment

The service focused on holistic care. Patients could access not only GP consultations but could access, for example, dieticians and physiotherapists. Consultations were in 30 minute blocks. The provider commented that they felt this ensured patients did not feel rushed, and clinicians had sufficient time to carry out a detailed consultation.

Patients had access to information about the GP and other clinical and non-clinical staff working for the service and could book a consultation with a practitioner of their choice. Patients were able to access their medical records at any time via their online account. Tests results were provided to patients via the service, and not directly to them, so clinicians reviewed them first.

The provider shared with us the results of their recent online patient survey, received from 14 patients over two days prior to the inspection. The provider received scores of between three and five (out of five) for the service it provided. Thirteen of the patients scored the service five when asked if they would recommend them to friends and family.

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

The website was available 24 hours a day, seven days a week. GP consultations were generally available between 7am and 7pm Monday to Friday; and between 7am and 12pm on Saturday and Sunday. 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. Any prescriptions issued were delivered within the UK to a pharmacy of the patient's choice, or sent to the patient.

The provider made it clear to patients what the limitations of the service were, including when the GP was not available. This happened, on occasion, for one to two weeks at a time. The provider told us that all patients were told of this in advance, and information was put on the provider's website. The provider stated they had not received any adverse feedback.

Patients requested an online consultation with a clinician and were contacted at the allotted time. Consultations were scheduled to last 30 minutes, but this could be extended if necessary.

Tackling inequity and promoting equality

The provider offered consultations to anyone who requested and paid the appropriate fee, and did not discriminate against any client group. Clinicians told us that they had not experienced any language barriers however as they expanded they would review the need to provide access for their staff to facilities such as language line.

Patients could access a brief description of the GP and other clinical and non-clinical staff on the services' website.

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 has been developed and introduced for use.

The provider was able to demonstrate that the complaints we reviewed were handled correctly and patients received a satisfactory response. We were sent a copy of the three complaints received by the provider since March 2017. They had not received any complaints prior to this date.There had been two relating to their dietician service, and one relating to fees. All appeared to have been appropriately dealt with.

There was evidence of learning as a result of complaints. We were provided with a breakdown of action taken in relation to concerns and feedback. For example, in response to a patient complaining of overcharging, the provider amended its policy, updated its clinicians and also discussed with the patient the different pricing schemes that were available.

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. Patients could opt for a one off consultation fee or sign up to a monthly or annual plan. The website had a set of terms and conditions and details on how the patient could contact them with any enquiries.

The GP 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. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP assessed the patient's capacity and, recorded the outcome of the assessment. If a young person was assessed as being competent under the Gillick competencies, then it was possible for them to have a private consultation if they wished (Gillick competence is used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge).

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 had a clear vision for their team to work together to provide an efficient, high quality, safe, responsive and holistic service. The provider had plans in place to expand the service building on its multidisciplinary team and holistic approach.

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 remotely. 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 clinical reviews. The information from these checks was reviewed at the regular clinical 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. Monthly clinical meetings were held. They had a standing agenda which included reviewing safety, clinical effectiveness, governance, patient focus and accessible and responsive care. Detailed minutes were kept and these were provided for the inspection.

Care and treatment records were complete, accurate, and securely kept. The provider had reviewed data security and concluded that it was inappropriate to use commercial (cloud) storage systems outside of the EU to store patient identifiable information and moved to more appropriate systems which complied with Information privacy and data protection laws.

Leadership, values and culture

At the time of this inspection the registered manager role was shared between two of the company founders, although they planned to change this to just one registered manager in the near future. One was the medical director, the other a physician's associate. The medical director had responsibility for any medical issues arising. There was a chief executive officer, responsible for the non-clinical operation of the service.

The medical director was the only GP available. In their absence, and because patient numbers were so small, there was no system in place to provide an alternative GP. We were told that patients were informed when the GP was going to be absent, and also that as the service expanded, so they would seek to employ additional GPs.

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

Systems were in place to ensure that all patient information was stored and kept confidential. Only clinicians could access patient records. Patient information was stored on secure servers, and each patient was given a password to enable them to access certain parts of the provider's website. Staff had access to policies and procedures to guide them through identifying patients.

We noted that patient photographs of medical conditions were sometimes uploaded and reviewed by clinicians via email. The service concurred that this was not the most secure way to obtain or review information that needed to be kept secure and told us they would review this practice. They also told us that they were building into their software the ability to monitor who asked for patient photographs, how often and the reason for it so as to ensure there were no inappropriate requests.

There were policies and IT systems in place to protect the storage and use of all patient information. The service used an online cloud-based electronic medical record (EMR). The data was transmitted and held in an encrypted format on a secure server within the UK. None of the medical data was passed or held overseas. The EMR provided two separate formats, one for each patient, which the patient had access to; the other for clinicians. Each iPrimary Care clinician was provided with their own username and password to access the EMR. All entries to the medical record were recorded and were available for audit. All clinician entries into the medical records were date:time

Are services well-led?

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

stamped with the clinicians names. The service could therefore 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.

New patients were asked to complete a basic registration form, and then could book an appointment for themselves or any family member. An email confirmation would be sent to the patient once the appointment had been made. The first appointment was carried out by video link, and the patient had to show photographic identification. Subsequent consultations could be via video link or by telephone, and the clinician would call the patient at the appointment time, and ask them to verify their identity. As the provider calls the patient for their appointment, they have not had to deal with any issues regarding withheld numbers.

At the time of this inspection patients registered with the service were corporate clients and as an additional security measure they had to provide a work email address.

Seeking and acting on feedback from patients and staff

Patients were emailed at the end of each consultation with a link to a survey they could complete, in which they could rate the service they received. This was constantly monitored and if fell below the provider's standards, this would trigger a review of the consultation to address any shortfalls. We reviewed the most recent survey results from 13 patients. With five being the highest score, almost all patients scored the service four or five. No score was below three.

Additionally, the GP contacted each patient after consultation/treatment to review how they were. We saw anonymised examples of patient responses from which it was evident that patients greatly appreciated this follow up.

There was evidence that the GP was 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.

Continuous Improvement

The service consistently sought ways to improve. It had developed its own online training modules specifically for digital care providers. It was looking at ways to enhance patient identification so as to reduce risk.

All staff were involved in discussions about how to run and develop the service, and were encouraged to identify opportunities to improve the service delivered. We saw from minutes of staff meetings where previous interactions and consultations were discussed.

The management team and associated IT company worked together at the headquarters which enabled ongoing discussions at all times about service provision. At the time of this inspection the provider was reviewing how it could further improve patient identification, including matching a scan of identification with a real time image.