# i-GP Virtual Doctor

## 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? | **Outstanding** |

# Overall summary

Letter from the Chief Inspector of General Practice

**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? – Outstanding

We carried out an announced comprehensive inspection at i-GP Virtual Doctor on 29 April 2019, as part of our comprehensive inspection programme and to provide a rating for the service.

The provider, Doc Reports Ltd provides an online clinic, consultation, treatment and prescribing service for a limited number of medical conditions to patients from England, Scotland and Wales (we only inspected the services provided to patients in England). This service is known as i-GP Virtual Doctor and is coordinated via the following website: www.i-gp.uk

At this inspection we found:

- The service had good 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.
- Prescribing was in line with national guidance, and patients were told about the risks associated with any medicines prescribed.
- 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.
- Following patient consultations information was appropriately shared with a patient's own GP in line with GMC guidance.
- The provider carried out checks to ensure consultations by GPs met the expected service standards.
- Staff involved and treated patients 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 i-GP Virtual Doctor

**Background**

Doc Records Ltd is registered for the following regulated activity: Treatment of disease, disorder or injury and provides an online consultation, treatment and prescribing service for a limited number of medical conditions to patients primarily from England, Scotland and Wales. The conditions treated are limited to a range of 25 minor conditions. For example, hair loss, contraception, sore throat, chlamydia, herpes, dental abscess, sinusitis, cystitis and urinary tract infections. A specific list of medicines that the provider can prescribe to treat these conditions is detailed on the provider's website. The service does not treat patients under the age of 18 and does not prescribe any pain relief, controlled drugs or high-risk medicines.

Doc Records Ltd consists of a team of 12 members which include the founder and chief executive officer (CEO), who is a GP and the registered manager, the chief medical officer (CMO) who is a GP, a chief of operations (COO), a chairman, finance and legal team and a medical board. Both GPs are registered with the General Medical Council (GMC), have a license to practice and were on the GP register and undertake remote patient consultations by reviewing patient's requests and completed medical questionnaires when they apply for prescriptions on-line.

The service is open between 8am and 10pm on a Monday to Sunday. However, patients can submit a request for treatment 24 hours a day, seven days a week on the provider's website. Requests for treatment are generally dealt with within one hour depending on when they are received.

This is not an emergency service. Subscribers, if assessed and approved, pay a consultation fee. The assessment process is such that patients complete an online assessment, once approved by a GP, treatment is prescribed. After completion of the assessment, some patients may require a telephone consultation to determine the best course of treatment.

Doc Reports Ltd is operated via a website () which is currently only available in English. The provider is in the process of introducing a translated version (100 languages).

**How we inspected this service**

Before the inspection we gathered and reviewed information from the provider. We visited Doc Reports Ltd at their registered address in Kings Hill, Kent and spoke to the CEO/registered manager and the chief medical officer. We looked at the records, policies and other documentation the provider maintained in relation to the provision of services.

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:**

- Systems and processes ensured care was delivered in a safe way.

**Keeping people safe and safeguarded from abuse**

Staff employed at the headquarters had received training in safeguarding and whistleblowing and knew the signs of abuse. All staff had access to the safeguarding policies and knew how to report a safeguarding concern. The safeguarding policy made it clear that concerns should be reported to the local authority where the patient resided and included links to access contact details of these authorities. Policies also contained information in relation to child exploitation and female genital mutilation. All the GPs had received adult and children level three safeguarding training. It was a requirement for the GPs registering with the service to provide evidence of up to date safeguarding training certification.

The whole team were engaged in reviewing and improving both safety and safeguarding systems which defined the core of the company mission. The service did not treat children and children were safeguarded from using the service with multiple steps to prevent misuse. When registering with the service a patient was asked to provide proof of identity in the form of a UK passport, their date of birth and address to help them ascertain that the patient was over the age of 18. As an additional layer of security, the provider also requested that photo ID was produced at the pharmacy where the prescription was collected to ensure the patient was not under 18 years of age. For example, for treatments prescribed for chlamydia and contraception.

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

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

The management team carried out a variety of checks daily and weekly. For example, consistency of consultation records, audits. These were recorded and formed part of a clinical team weekly report which was discussed at clinical meetings. The range of clinical and non clinical meetings comprises the two lead GPs, the COO, the Chairman and on occasion the medical board members.

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 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 to ensure the location of the patient at the beginning of the consultation was known, so emergency services could be called.

All clinical consultations were rated by the GPs for risk. For example, a high risk consultation would be one where the GP thought there may be serious mental or physical issues that required further attention. Consultation records could not be completed without risk rating. Those rated at a higher risk or immediate risk were reviewed with the help of the management and clinical director. All risk ratings were discussed at weekly clinical meetings. There were protocols to notify Public Health England of any patients who had notifiable infectious diseases.

A range of clinical and non-clinical meetings were held with the staff (the two GPs and where applicable, locum GPs), where standing agenda items covered topics such as significant events, complaints and service issues. Clinical meetings also included case reviews and clinical updates. We saw evidence of meeting minutes to show where some of these topics had been discussed. For example, improvements following a significant incident and clinical pathways in line with national guidance. Meeting minutes also gave details of changes to medicine safety alerts, as well as the summary of product characteristics (SmPC – which is a legal document approved as part of the marketing authorisation of each medicine and is the basis of information for healthcare professionals).

**Staffing and Recruitment**

Good

# Are services safe?

There were enough 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.

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

Potential GP/doctor locums had to be currently working in the NHS (as a GP if applicable), have online consultation experience and be registered with the General Medical Council (GMC), as well as a license to practice. They had to provide evidence of having professional indemnity cover, an up to date appraisal and certificates relating to their qualification and training in safeguarding and the Mental Capacity Act.

Locum GPs were supported during their induction period and an induction plan was in place to ensure all processes had been covered. We were told that GPs did not start consulting with patients until they had successfully completed several test scenario consultations. The GPs could not be registered to start any consultations until these checks and induction training had been completed.

We reviewed two staff files which showed the necessary documentation was available. The provider kept records (on a secure cloud storage system) for all staff including the GPs and there was a system 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 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 the patients' pharmacy of choice. The GPs could only prescribe from a set list of medicines which the provider had risk-assessed, with the exception of in emergency cases. For example, asthma preventer inhalers, but if this happened, it would be reviewed. There were no controlled drugs on this list. Therefore, this exception would not be extended to controlled drugs. The service's website advertised which medicines were available and there were systems in place to prevent the misuse of these medicines. There were computer algorithms to prevent:

- Repeat prescription overuse.
- Patients trying to register using multiple accounts.
- Contraindications for certain medicines.
- Treatment of patients with complex comorbidity.
- Children accessing the service.

Once the GP prescribed the medicine and appropriate dosage, 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. Instructions were available on the website and sent as a document to the patient by email following their consultation completion.

Repeat prescriptions were only issued for certain medicines. For example, allergy medicines for hay fever. When prescribing antibiotics, the provider made clear reference to antibiotic guidelines. The service encouraged good antimicrobial stewardship by only prescribing from a limited list of antibiotics which was based on national guidance.

There were protocols for identifying and verifying the patient and General Medical Council guidance, or similar, was followed.

We were advised that patients could choose a pharmacy where they would like their prescription sent to, for the prescribed medicines to be dispensed. Doc Reports Ltd had a prescription validator service for pharmacists to follow. This helped to them to dispense i-GP prescriptions safely and prevent fraudulent use. The system allowed the pharmacist to check a patient's date of birth and the prescription authorisation code, when the prescription was being collected by the patient. Additionally, it would issue a warning message if the prescription had already been collected.

**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**

Good

# Are services safe?

There were systems for identifying, investigating and learning from incidents relating to the safety of patients and staff members. We reviewed one incident and found that this had been fully investigated, discussed and as a result action was taken in the form of a change in processes. For example, following the significant event, highlighted in patient feedback, the provider had removed the Prescription Validation Process (on this occasion) on the hand-written private prescription, to prevent recurrence of the problem. Additionally, the provider had also added extra information at selected points to educate patients and alleviate any concern over collecting medicines, additional information had been added in emails to highlight to patients that if any issues were experienced in collecting medicines to contact i-GP, so that these could be dealt with and their "contact us" page had also been updated with this information.

The provider had an open culture in which all safety concerns raised by staff and people who use the service were highly valued as being integral to learning and improvement. This was evidenced through the active review of survey responses and feedback from patients to constantly review processes and instigate change where deemed necessary.

We saw evidence from one incident 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 effective?

**We rated effective as Good because:**

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

**Assessment and treatment**

We reviewed eight 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. We saw that services were regularly reviewed and updated in accordance with National Guidelines. For example, recent updates to antibiotic prescribing announced by NICE in March 2019 had been implemented to every day practice and the provider kept a detailed log of upcoming national policy changes.

We were told that each online consultation lasted for approximately 15 minutes. If the GP had not reached a satisfactory conclusion, there was a system where they could contact the patient again. Patients were offered information about their diagnosis, how to prevent recurrence of the problem, diet advice to boost the immune system, over the counter remedies, self-care strategies and even side effects of prescribed medicines.

Patients completed an online form, which was a set of 50 questions relating to their current symptoms and 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. We reviewed five anonymised medical records which were complete records. We saw that adequate notes were recorded and the GPs had access to all previous notes.

As a consequence of consultations, patients received real time triaging, an automated email follow up, GP summary sharing and an additional phone call, email or text support (where deemed necessary).

We also reviewed the medical questionnaires, which patients completed when requesting services. These were tailored to the condition they were seeking treatment for. Additionally, bespoke created algorithms to compare patient responses and digital gatekeeping to prevent patients from having multiple efforts at the same assessment; automatically prevented patients from seeking treatment for certain conditions. For example, patients who indicated they had complex comorbidity or male patients trying to request contraceptive pills.

The GPs providing the service were aware of both the strengths (speed, convenience, choice of time) and the limitations (inability to perform physical examination) of working remotely from patients. They worked carefully to maximise the benefits and minimise the risks for patients. If a patient needed further examination, they were directed to an appropriate agency. The provider used detailed clinical triage based on NICE guidelines with assessments of physical data using remote diagnostic aids. For example, inbuilt Sepsis screening to promote clinical safety. Additional internal scoring networks (to grade patient symptoms) and provide an evidence base for treatment such as the FEVERPAIN score, along with the creation of i-GP's own scoring methodology; also supported the assessment and care process. If the provider could not deal with the patient's request, this was explained to the patient and a record kept of the decision.

Patients received two weekly surveys to ascertain the outcome of their treatment. The service monitored consultations and carried out consultation and prescribing audits to improve patient outcomes. For example, a case review in relation to urinary tract infections (UTIs) prescriptions had been conducted. The review included reviewing all prescriptions made for UTIs and whether they met the Target Antibiotic Toolkit (TAT) framework. As a consequence of the review, Doc Reports Ltd had confirmed that their formulary and UTI pathway was being strictly adhered to.

Additionally, there was a 'red flag' monitoring system for follow up of patients. Whereby patients who described clinically significant symptoms, such as haemoptyisis (coughing of blood) or haematuria (blood in urine), were are actively followed up. We saw that continuity of care was offered by the suggestion of sharing the encounter with their own GP.

**Quality improvement**

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

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

Good

# Are services effective?

- The service took part in quality improvement activity. For example; audits, reviews of consultations and prescribing trends.

**Staff training**

All staff had to complete induction training which consisted of an overview of the structure of the service, policies and procedures, health and safety, information governance and other relevant topics. Staff also had to complete other training on a regular basis. For example, health and safety, information governance, general data protection regulations, basic life support, sepsis recognition and management, conflict resolution, safeguarding adults and children, adverse reaction to medicines and reporting these. The management team had a training matrix which identified when training was due, records we reviewed confirmed this.

All the GPs had to have received their own appraisals before being considered eligible at recruitment stage. GPs had their own NHS appraisal in addition to in-house appraisals. Records were maintained of all appraisals conducted.

**Coordinating patient care and information sharing**

Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history. 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 to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service. Where patients declined, the service's website was clear that should a patient be assessed, and information was required to be shared with their own GP, treatment may be declined.

Audit activity of information sharing showed that 65% of people had consented to share information with their own GP. The audit showed that in all cases, the information was shared as agreed.

The provider also had policies and procedures for patients requesting prescriptions, when they were not registered with a GP or their GP practice had closed. Patients of this type were appropriately signposted to resources for registering with a GP and were sent an email or letter 14 days later to verify that they had registered, in order for care summary records to be sent.

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.

The service monitored the appropriateness of follow ups from test results to improve patient outcomes. For example, when blood tests were required to be taken by the patients' own GP, in the event of suspected Lyme disease following a tick bite.

**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: sleep, stress, diet, exercise and how to self-treat recurrent cystitis.

In addition, the provider had developed a patient education program known as Wellness, which not only focused on physical health such as diet, exercise and illness prevention, but combined all aspects of well-being including physical, mental, emotional and spiritual needs. This aimed to promote maintaining a healthy lifestyle, disease prevention and the importance of regular health checks. For example, patients prescribed contraception with borderline body mass index (BMI) rates were advised to keep their BMI below 30 and were provided with weight management advice.

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

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**

All staff had undertaken training on their roles and responsibilities in relation to data protection and information governance and the provider was registered with the Information Commissioner's Office. The GP could access patient records remotely but ensured this was always done in a private and secure location, which were appropriately risk assessed. The computer system used by the service was encrypted.

The provider's website enabled patients to leave feedback and we saw evidence of appropriate action being taken when negative feedback was received. For example, methods of payment had been changed to ensure debit and credit card transactions were not overly complicated or costly in terms of additional charges.

Patients were respected and valued as individuals and were empowered as partners in their care, both practically and emotionally. We were unable to speak to any patients during the inspection. However, we reviewed the latest survey information. At the end of every consultation, patients were sent an email asking for their feedback. The provider utilised an online feedback platform, from which we saw that there were 184 responses in the last 12 months (181 positive, one negative and two contained mixed feedback). Positive responses confirmed that that patients had received excellent services and were listened to by GP's. Negative responses related to matters beyond the scope of practice of the services provided and mixed feedback related to errors that had occurred but had been easily and quickly resolved. The providers records showed that there was a reuse likelihood rating of 98.5% from the patients.

**Involvement in decisions about care and treatment**

Patients were able to access their notes and records via the patient portal which they could sign into via the website using the password they had created when registering with the service.

Patient information guides about how to use the service and technical issues were available. A member of staff was available to respond to any enquiries.

Patients were educated about treatment. For example, changes in antibiotic duration changing from seven days to five days (for certain illness'), the effectiveness of nationally recommended treatments and were also offered free follow up advice if required.

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.

**Responding to and meeting patients' needs**

Consultations were provided seven days a week, 8am and 10pm, 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.

The provider used a responsive online treatment platform for minor illnesses, which offered real-time assessment using Si (a version of swarm intelligence, created by doctors to improve your health). The use of Si also enabled the online prescription validation service, for pharmacists to confirm issuing of the prescription ensuring clinical safety.

The digital application did not allow people to contact the service from abroad. Any prescriptions issued were delivered within the UK to a pharmacy of the patient's choice.

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

Through the website, patients requested an online consultation with a clinician / GP and were contacted at the allotted time. The maximum length of time for a consultation was approximately 15 minutes. However, we were told that GPs could contact the patient if they had not been able to make an adequate assessment or give treatment.

**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.

Patients could access a brief description of the GPs available. Patients could choose either a male or female GP or one that spoke a specific language or had a specific qualification. Where language barriers existed in relation these requests, interpretation services were utilised. Type talk was available.

There was a strong organisational commitment towards ensuring that there was equality and inclusion across the workforce.

**Managing complaints**

Information about how to make a complaint was available on the service's website. The provider had developed a complaints policy and procedure. The policy contained appropriate timescales for dealing with the complaint. There was escalation guidance within the policy. 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 the one complaint received within the last 12 months.

The provider was able to demonstrate that the complaint we reviewed was handled correctly and the patient received a satisfactory response. There was evidence of learning as a result of the complaint received, changes to the service had been made following complaint, and had been communicated to staff.

**Consent to care and treatment**

There was clear information on the service's website with regards to how the service worked and what costs applied, including a set of frequently asked questions for further supporting information. The website had a set of terms and conditions and details on how the patient could contact them with any enquiries. Information about the cost of the consultation was known in advance and paid for after the digital consultation had been completed. The costs of any resulting prescription were handled via a secure payment method.

All GPs/staff 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. The provider used technology used to ascertain mental capacity of patients. 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. The process for seeking consent was monitored through audits of patient records.

Outstanding ☆

# Are services well-led?

**We rated well-led as Outstanding because:**

- It was led and managed effectively and drove the delivery and improvement of high-quality, person-centred care and because leaders had an inspiring shared purpose.

**Business Strategy and Governance arrangements**

There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans. We were told that plans were consistently implemented to cover IT, service improvement and information governance, and have a positive impact on quality and sustainability of services.

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 and were in line with the NHS ten year plan for digital health technologies.

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 business continuity plan which included details of actions to be taken by staff, in the event of loss of premises or IT function. We saw that appropriate arrangements had been made for the secure storage and tracking of blank prescriptions had been made.

There were a variety of daily, weekly and monthly checks 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 was strong collaboration, team-working and support across all functions of the service and a common focus on improving the quality and sustainability of care and people's experiences of service. There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

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

**Leadership, values and culture**

The CEO/registered manager had overall responsibility for the day to day operation of the service. The CMO had responsibility for any medical issues arising. There were systems to address any absence of this clinician both planned and unplanned.

The values of the service were: Doc Reports Ltd believe that everyone is entitled to flexible and efficient healthcare. As a consequence of this, i-GP was created after evaluating the period of time patients took to see a doctor for low-risk conditions. As a doctor founded and doctor-led service, i-GP was focused on patient safety. They aimed to offer access to the highest level of online care in a manner which was centered on the patient's need for timely care.

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

**Safety and Security of Patient Information**

There were systems to ensure that all patient information was stored and kept confidential.

Policies and IT systems protected 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 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 and add any comments or suggestions. Survey questions included (but were not limited to); the overall impressions of the website, the online assessment process, how they would rate the service provided, if any further treatment was required from their own GP for the same after using the services, whether they would like to join the Wellness programme. A summary of patient feedback was published on the service's website.

Outstanding ☆

# Are services well-led?

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

The provider had a whistleblowing policy. (A whistle blower is someone who can raise concerns about practice or staff within the organisation.) The CEO/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. Meetings were held either in person or remotely through online meeting facilities. Staff told us that the monthly team meetings were the place where they could raise concerns and discuss areas of improvement.

There was a quality improvement strategy and plan to monitor quality and to make improvements. For example, through clinical audit. We saw that monthly audits were conducted relating to earache prescribing, UTI prescribing, acne prescribing. The provider made consistent use of a recognised improvement methodology. Improvement was seen as the way to deal with performance and for the organisation to learn.

The service were aware of the national plans for increased digital care provision in primary care and their objective for within the next 12 months was to integrate with the NHS, expand the number of patients treated and continue the development of evidence based treatments. Additionally, the provider was working with the NHS in the London Digital Health Accelerator for NHS integration, as part of the new NHS Ten Year Plan.

The i-GP team contributed to research (results of which had been presented at international conferences and were awaiting publication) and the development of national guidance for online services. For example, its work with the NICE Clinical Evidence Framework, where they had already been assigned tier 3B (the highest grade possible for digital care providers. Tier 3b evidence standards apply to digital health technologies that are designed to provide or guide treatment, active monitoring and clinical calculations, or provide or guide a diagnosis).

Safe innovation was celebrated and there was a clear, systematic and proactive approach to seeking out and embedding a new and more sustainable model of care. The provider had a strong record of sharing work locally, nationally and internationally.

The providers website detailed a variety of awards the service had been nominated for, in relation to their technology and IT Innovation.