AlldayDr Group Ltd

Inspection report

77-79 Church Street
Blackrod
Bolton
BL6 5EE
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Date of inspection visit:
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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	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

Overall summary

Letter from the Chief Inspector of General Practice

We rated this service as Requires improvement **overall.**

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at AlldayDr on 12 February 2020 as part of our inspection programme. This was their first inspection.

AlldayDr is an online healthcare provider that offers a consultation service with a GP through a Smart phone app and online web portal. Patients can register via the online web portal or smart phone app and patients are able to pay either a one-off fee or subscribe to the service.

We rated the service as requires improvement overall. We rated the safe domain as requires improvement because on the day of the inspection risk management, quality assurance and prescribing were not failsafe. We rated the well led domain as requires improvement because on the day of the inspection the provider was not aware of the areas where patient safety may be compromised or other potential risks.

At this inspection we found:

- Not all systems to manage the risks associated with digital patient care and treatment were failsafe. For example, at the time of the inspection the provider did not have an effective system in place to receive and act on medicines and safety alerts, such as those issued by the Medicines and Healthcare products Regulatory Agency (MHRA).
- The service reviewed the effectiveness and appropriateness of the care it provided. It usually ensured that care and treatment was delivered according to evidence-based guidelines. However, we did see some examples where this was not the case. For example, contemporaneous notes were not written in accordance with current guidelines.
- Prescribing was carried out by the GP reviewing patients. However, this was not always in accordance with prescribing requirements.
- We saw items that appeared to be for sale on the service website that on further review were not purchasable. This was misleading to people reviewing the website. When this was pointed out to the provider the items were immediately removed from the website.
- Consent to share information with a patient's NHS GP was obtained at the point of sign up. However, no information had ever been shared following any of the consultations.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- Patients could access care and treatment from the service within an appropriate timescale for their needs.
- Staff met regularly to discuss consultations, incidents, and any learning that could be applied or improvements that could be made.
- There was no clinical peer review of GP consultations to ensure they were effective and followed appropriate guidelines. For example, although a clinical care audit tool was in place, the audit had been undertaken by a non-clinical manager.
- All staff had received appropriate training for their role.

The areas where the provider **must** make improvements are as follows:

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

The areas where the provider **should** make improvements are as follows**:**

- More clarity was required to ensure all clinicians (once the service is scaled) understood the service expectations and importance of sharing information.

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 AlldayDr Group Ltd

AlldayDr Group Limited is the provider of AlldayDr, an online video GP consulting service.

We inspected AlldayDr Group at their offices based at AlldayDr House, 77 Church Street, Blackrod, Bolton, BL6 5EE.

AlldayDr is located on the ground floor and rear of a pharmacy building with a pharmacy which is an independent business.

Patients are not treated on the premises and the current GP carries out on-line consultations remotely from various suitably private locations.

The provider is currently the GP for the business and is registered with the General Medical Council (GMC). They also work within the NHS. The service does not treat anyone under the age of 18 years.

The service aims to provide an affordable and responsive alternative to traditional NHS services.
Doctors are GMC regulated and deliver services from an online platform and Smart phone app. Services offered include:

- Online GP services offering face to face video consultations with GMC registered UK GP's.
- Delivery and dispatch of NHS Repeat prescriptions through partner pharmacies.
- Ordering of medication without the need for a face to face consultation via an in-depth medical questionnaire that is reviewed by a GP before approval is given.

The provider aims to upscale the service to a Business to Business (B2B) model. This is a form of transaction that is conducted between companies rather than between a company and individual customers. Once a contract has been secured, the provider will employ more GPs to provide the service. In addition, the provider is working with the NHS and has obtained IM1 pairing accreditation. IM1 pairing is the process that allows suppliers to integrate their system with any principal clinical system through an interface mechanism. Interface mechanisms enable separate systems to read patient information, extract information in bulk and enter data in to the other system. This will provide consulting GPs with complete information sharing abilities (with patients' consent) and enhance effective outcomes for patients by providing a full patient/GP to patient/GP experience.

Currently, patients are asked to set up a profile and identity checks are undertaken. Once their identity has been verified, patients are able to book a ten-minute consultation (or longer if selected) with a GP between the hours of 8am and 10pm seven days a week. The smartphone app allows users to have video consultations with a GP. Currently there is one GP who will ask relevant questions relating to the condition or issue the patient has raised. Following the consultation, if appropriate, a private prescription or a referral letter to another service can be provided.

Prescriptions are delivered by secure methods of transport to the patient's choice of location. This can be their home or place of work. Alternatively, they can collect the prescription from a designated collection point or a pharmacy of their choice.

Patients can subscribe to the online service either via a monthly subscription package or pay per consultation. Patients can give feedback about the service via the app.

The provider who is also the CEO is the clinical lead for the service. The current registered manager is on maternity leave. A registered manager is a person who is registered with the Care Quality Commission (CQC) 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. At the time of the inspection under 50 patients had used the service. 395 people had registered to the site and were eligible to have an advice only video consultation.

AlldayDr had not been inspected before.

How we inspected this service

Before the inspection we gathered and reviewed information from the provider. During this inspection we spoke to the service manager and members of the clinical and administration team.

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

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

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

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Requires improvement

Are services safe?

We rated the service requires improvement in the safe domain because health and safety were not sufficiently monitored, and potential risks were not sufficiently identified, to ensure patient safety.

Keeping people safe and safeguarded from abuse

At the time of the inspection staff employed at the service consisted of the provider and consulting GP, three administrative staff and six managers.

All staff had received training in safeguarding where it was deemed necessary. There was an induction pack prepared for any newly employed staff which covered safeguarding requirements, and whistleblowing policies and procedures. We saw that these were all accessible on an electronic shared system.

All staff had access to the safeguarding policies and where to report a safeguarding concern. The safeguarding policy stated that the registered manager was responsible for documenting, contacting and reporting any concerns to other authorities and ensuring patient records were updated. The policy contained all the local authority telephone numbers to report any concerns. There was a safeguarding button on the IT operating system to alert staff to any NHS safeguarding information.

The provider was the lead GP and had undertaken appropriate safeguarding training to level seven in both adults and children. It was a documented requirement for any GPs employed by the service in the future to provide evidence of up to date safeguarding training certification and there was an expectation by the provider that all staff would be updated annually.

The service was only available to persons over the age of 18 years.

Monitoring health & safety and responding to risks

The service head office was located within modern offices which housed the IT system and a range of administration staff. Patients were not treated on the premises as the GP carried out the online consultations remotely from various private locations. Staff based in the premises had undertaken training in health and safety including fire safety. Safety was covered in induction packs for any new starters. There was an emergency push-button on the IT system.

Laptops were secure and there was a unique way for each member of staff to log on to the operating system which was a secure programme. The provider expected that all consultations would be provided in private and maintain patient confidentiality. At the time of the inspection the service did not determine the patient's location at the start of consultations. Once we pointed this out a change was made immediately to the locum induction pack and the policy was altered. In addition, we were informed that changes were being made to the technology that would automate sharing of GEO location of the patient upon them joining the call. Going forward the service said they intended to make it mandatory that consulting doctors asked the exact location of the patient and they would not be able to continue the consultation unless that was verified.

At the time of the inspection 395 patients had registered and had access to a GP for an advice only video consultation provision. However only 38 patients had uploaded the required documentation and could receive prescriptions, sick notes and/or referrals.

We reviewed all the patient consultations that had taken place and saw that questionnaires were completed to establish each patient's individual needs and preferences. We noted that some questionnaires relied on the patient's own free-text information and indicated potential risks if this practice were to continue. For example, after each question on the questionnaire, the patient was informed if their answer made it unsafe for them to take the requested medicine. Patients were able to change the answer to fit the requirements to obtain the medicine and doctors, when reviewing the answers, were unaware that the patient had changed their answers.

When this was pointed out by the inspection team, the provider made changes to the questionnaires to prompt yes/no answers and pre-populate any required additional questioning before consultation.

The provider knew what to do where any patients with notifiable infectious diseases were identified and there was a policy in place to notify Public Health England.

A range of non-clinical meetings were held with staff, where standing agenda items covered topics such as complaints

and service issues. Clinical discussions happened between the provider (lead GP) and the non-clinical staff. The provider also undertook peer review with a colleague outside the service.

Staffing and Recruitment

There was enough staff, including the GP, to meet the demands of the service. No rotas were required, and all consultations so far had been carried out by the provider.

There were policies and procedures in place to enable the service to grow. We reviewed the recruitment procedure which ensured that all the required checks were undertaken before employment. They included references, Disclosure and Barring Service (DBS) checks, and a full induction pack. (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).

We saw recruitment policies in place, stating what documents and assurances were required and what protocols were to be used if the service expanded, as was its intention.

We were told that newly recruited GPs would be supported during their induction period and we saw the induction plan in place which covered all processes. We were told that GPs would not start consulting with patients until they had successfully completed several test scenario consultations. At the time of the inspection, we pointed out that video consultations could only be viewed by the GP who had undertaken the consultation. This was something that required improvement because contemporaneous notes were not written in accordance with current guidelines.

We reviewed the recruitment file of the provider which showed all necessary documentation about employment history, training and education was available. We also saw that the provider kept records for all other staff (who were administration staff). The service manager was responsible for the system that flagged up when any documentation was due, training was due for update, or professional registration was due for renewal.

Prescribing safety

Medicines were issued to a patient after completing a questionnaire, which would be reviewed by a doctor to authorise, or following an on-line video consultation. Once a questionnaire was authorised and medicines were supplied, they would either be posted to the patient at home, or the patient could collect them from the pharmacy attached to the provider.

When we reviewed the questionnaires, we found that some did not ask enough relevant questions to check whether it was safe for a patient to have the medicine they were requesting. For example, a patient might find that the answer to a question identified that the medicine they requested was not safe for them and they would not be able to request it. However, we found that the system allowed the patient to change their answers (if they did not like the outcome) and the prescriber was not informed of any failed questions. This meant a patient could be issued a medicine that was not safe for them to take and the prescriber would not know that the information had been changed. Immediately following the inspection, we were told that several changes were made to the system to improve prescribing safety and some questionnaires were removed altogether.

If a medicine was to be prescribed following an on-line video consultation, the patient had a choice where they could receive their medicine. They could take the prescription to a pharmacy of their choice, click and collect from a pharmacy of their choice or have the medicine delivered by a one of the service's partner pharmacies. In addition, where applicable, patients were advised of any cheaper over-the-counter alternatives.

The GP would then document the consultation onto the patient's record. When we reviewed the documented consultations, we saw that previous medicine history and detail of any patient's allergy status was not always recorded. We reviewed video consultations and documented consultations and found they were not consistent with each other. Information discussed in the video consultation was not fully recorded in the patient's medical notes. If a patient therefore returned to the service for a further consultation, the previous video consultations were not viewable and only the documented notes (which were not a full record of the consultation) could be seen. We were informed immediately following the inspection that previous medical history was always implemented and present within the clinical system, although "hidden"

because of role-based access. A way to view previous medical history was demonstrated to our GP SpA on the day of the inspection and through a video link sent to the lead inspector immediately after the inspection.

At the time of the inspection, it appeared that not all documented information about a patient was available to view. Whilst reviewing prescribing within clinical records we saw that some medicines had been declined. We were unable to see any documented reason or consultation to explain the refusal. On discussion with the provider it was unclear how future GPs undertaking a repeat consultation of a patient would be able to view or review such information. At the time of the inspection we were advised that ways to view patient history had been demonstrated to a member of the inspection by the provider who explained that information was available only by role-based access. Immediately following the inspection, the provider sent a video link demonstrating to the lead inspector that all information about a patient, including all patient history (if it had been recorded) would be available to view by any clinician with the appropriate role-based access. The provider shared screen shots on how this would be demonstrated to any new clinical members joining the service.

The prescribing system enabled doctors to be able to prescribe (privately) from the full standard NHS formulary and was not limited to reflect the modality and scope of practice of the service. This allowed doctors to prescribe any medicine. Medicines, including schedule 4 and 5 drugs, that may be abused or misused could be prescribed by doctors. We were told that doctors would be encouraged to prescribe a minimum number of tablets and had the option to inform the patient's GP. We were told that the service encouraged good antimicrobial stewardship by encouraging prescribers to follow national guidance. However, at the time of the inspection there was only one prescriber who was the provider and they said that no controlled drugs had ever been prescribed.

Immediately following the inspection, the provider reflected on policies and procedures in place to mitigate prescribing risks when the service grows. As a result, we were told they had updated protocols for prescribing controlled drugs, blocked the system from allowing prescribing of controlled drugs and updated their medicines management policy. They said they had reviewed all other drugs liable to misuse or abuse and updated protocols so that those could only be prescribed once information had been shared with the patient's GP. They stated that prescribing of those drugs would be closely monitored and audited in the future. They also told us that they had improved the way unlicensed medicines were prescribed and how patients would be better informed as to what this meant.

The provider did not offer repeat prescriptions; patients had to have a consultation with a GP every time a medicine was prescribed. The service was not aimed at patients with long term conditions that may need to be monitored.

On the day of the inspection we saw several medicines advertised on the website which were not available for sale. We also saw that questionnaire for prostate cancer could be completed, with a view to purchasing required medicines at the end. At the time of the inspection, on completion of the questionnaire, the medicines were not available. We informed the provider that this was misleading patients. Following the inspection, the provider informed us they had taken appropriate measures to remove any medicines that could not be purchased and improved patient questionnaires so that only those with available medicines could be completed.

Information to deliver safe care and treatment

On registering with the service, and at each consultation a patient's identity was verified. Verification instruction was part of induction training and was included in the clinical training manual. However, at the time of inspection, checking a patient's identity at each consultation, was not a mandatory requirement and the next person reviewing the patient did not have access to the previous video consultation.

At the time of the inspection the only other information available to the person conducting the consultation were the documented consultations.

After the inspection, the provider informed us that a change had been made. As part of training for GPs carrying out a consultation, identification checks would become a mandatory requirement. To further mitigate any issues a "radio" button would be implemented on the portal to make it mandatory for ID checks to be completed and it would not be possible to commence further if these identification checks had not been completed.

Requires improvement

Are services safe?

Consent to share information with a patient's NHS GP was obtained at the time of each consultation. However, at the time of the inspection, no information had ever been shared following any of the consultations, even though some patients had indicated their consent to share. We discussed this with the provider during the inspection, re-enforcing the importance of sharing information regarding patients' health and treatment to promote a safer and more effective delivery of care.

After the inspection, the provider told us they made information sharing a mandatory requirement when registering with the service. Going forward the provider said this would be mitigated by direct electronic communication to the patient's GP via an NHS integration tool through where the provider would also be able to read and write (with patient's consent) into the patient's GP clinical record. This is something that the provider was currently working on but was not yet an available resource.

The provider also told us that going forward, future GPs would be instructed that information sharing was good practice and to be encouraged. In the event of a patient refusing to give consent, the system had been changed to mandate a documented reason for refusal.

Management and learning from safety incidents and alerts

There were systems in place for identifying and investigating incidents relating to the safety of patients and staff members and evidence to demonstrate that learning was discussed and reviewed. We reviewed all the incidents that had been recorded and saw they had been fully investigated, discussed and used to change protocol.

There was no specific evidence, nor incidents that met the threshold to demonstrate that the provider was aware of and complied with the duty of candour. However, we did see an incident where a patient had been offered an apology when something went wrong and they were advised what action had been taken.

At the time of the inspection the provider did not have an effective system in place to receive and act on medicines and safety alerts, such as those issued by the Medicines and Healthcare products Regulatory Agency (MHRA).

After the inspection an updated policy was sent to us to ensure alerts were dealt with. Also, to improve this further, the Provider has planned to implement a "tick box" button on the portal to make it mandatory that GPs working for the service have confirmed they are up to date with current safety alerts. They also planned to develop and install an internal "intranet" system for the dissemination of safety alerts, updates and any other learning which will be auditable to ensure compliance.

There were systems in place to ensure that the correct person received the correct medicine.

Good

Are services effective?

Assessment and treatment

We reviewed 15 video consultations and clinical records with the provider, as well as other consultations carried out by way of questionnaires. There was one GP assessing/ consulting patients at the time of the inspection. We saw that in each case an assessment of need was made in line with relevant and current evidence-based guidance and standards, including National Institute for Health and Care Excellence (NICE) evidence-based practice. We were told that each online consultation lasted for ten minutes at which time the system ended the consultation without warning, although this had never occurred. We were told that if a consultation did happen to end without warning, then the patient could be re-contacted, but at the time of the inspection there was no way to override the possibility.

The service used NICE guidelines and BNF as support tools in providing treatments. Questionnaires required reviewing to ensure they were safe. We discussed these concerns during the inspection and the provider reflected and made changes to the system and protocols immediately to resolve this.

The provider of 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 and accepted any shortcomings. We were told if a patient needed further examination, we were told they were signposted to an appropriate agency, but we did not see any occasions when this had been necessary. If the provider could not deal with the patient's request, this was explained to the patient which was recorded on video, but not always in the clinical record.

The service monitored consultations and carried out consultation and prescribing audits to improve patient outcomes. The provider undertook peer review of consultations with a colleague outside the service.

Quality improvement

The service collected and monitored information on patients' care and treatment outcomes. There was a system in place to audit consultations with the consulting GP involved in those audits alongside the service manager.

Staff training

All staff completed induction training which consisted of health and safety, safeguarding and customer service. The service manager had a training matrix which identified when training was due.

There was a policy in place to ensure that GPs registered with the service received specific induction training prior to treating patients. However, at the time of the inspection there was only the provider in place. An induction log was available to be held in each staff file and signed off when completed. Supporting material was available, when other GPs did join the practice, such as a GPs handbook, guidance on how the IT system worked and aims of the consultation process. There was also a newsletter to be sent out when any changes were made. We saw several areas of support for GPs (in the future when the service is scaled) including clinical and technical protocols.

Administration staff received regular performance reviews. The provider GP had received their own appraisal and there was a protocol in place for monitoring the performance of GPs in the future both at the time of recruitment and during employment.

Coordinating patient care and information sharing

At the time of the inspection there had been no referrals to other services. We discussed this during the inspection along with the need to ensure that there were appropriate information sharing protocols.

If a patient needed a face-to-face consultation, they were advised to seek an appointment with their own registered GP. This was not something that had been facilitated yet.

Patients were asked for their consent to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service. More clarity was required to ensure that patients were advised of the risks of not informing their GP if they decided to opt out of that opportunity. At the time of the inspection there was an understanding that notes would be shared with a patient's registered GP "when required". More clarity was required to ensure all clinicians (once the service is scaled) understood the service expectations and importance of sharing information.

The service was able to refer patients for private treatment or the service was able to signpost patients to their NHS GP if they had any concerns, but this was not something that had ever been facilitated at the time of the inspection.

Good

Are services effective?

Supporting patients to live healthier lives

The service identified patients who may need extra support and had a range of information available on the Smart phone app such as healthy eating.

Patients treated for STIs (sexually transmitted infections) would be signposted to GUM (Genito-Urinary Medicine) clinics or given advice on STI prevention.

Good

Are services caring?

Compassion, dignity and respect

The provider undertook video consultations in a private room and were not disturbed at any time during their working time. The provider was able to ratify this as they were the GP undertaking consultations at the time of the inspection. In the future when the service was scaled up, and there were more GPs, the provider intimated the expectation that this would be the case for all employees undertaking consultations. A protocol and guidance were already in place.

Patients and staff were aware of preferences and settings within the system to maximise privacy and we saw that staff were given role-based access to patient information.

Patients who had used the service would receive a text message or email from the provider to which feedback could be provided. It was the patient's choice as to whether they wished to provide that feedback and was not compulsory. Completed feedback forms were then sent to the analytics portal so that the information could be monitored. Positive feedback comments would then be posted on the website. If any negative feedback was received this was reviewed and if required, would be used to improve the service in that specific area.

40% of patients rated the consulting doctor 5 star and 60% rated them 4 star. There was only one consulting doctor at the time of the inspection and this was based on ten responses received.

Involvement in decisions about care and treatment

Patient information guides about how to use the service and technical issues were available. There was a dedicated team to respond to any enquiries. Patients had access to information about the GP working for the service. At the time of the inspection there was only one GP available for consultation. A female GP was not available for consultation. Information was only available in English.

Patients could have a copy of their video consultation if they requested it.

The survey asked patients who used the service to rate the doctor undertaking the consultation and the service provided between 1 and 5 stars. They were then asked to rate whether they would recommend the service between very likely and very unlikely and provide any feedback in areas that could be done better.

We looked at the feedback that had been received from ten patients who had used the service in 2019 (those were the only results available). 9% rated the service 2 stars, 54% 4 stars and 36% 5 stars.

Overall patients who used the service in 2019 said they would recommend it to others. CQC directly received positive responses about the service from five patients who had used it.

Good

Are services responsive to people's needs?

Responding to and meeting patients' needs

Consultations were provided seven days a week, 8:00am to 10.00pm. 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 digital application allowed people to contact the service from abroad, but all medical practitioners were required to be based within England. Any prescriptions issued could be delivered to the patient's choice of delivery such as their home or place of work, or collected from a collection point, rather than having to visit a pharmacy.

Patients signed up to receiving this service on a Smart phone app (iPhone or android versions that met the required criteria for using the app). The service offered flexible appointments between 8am and 10pm to meet the needs of their patients.

The provider made it clear to patients what the limitations of the service were. These were discussed during consultations and further information about services was available on the website.

Patients requested an online consultation with a GP and were contacted at the allotted time. Consultations were undertaken in ten-minute slots and more than one slot could be selected. We saw during the inspection that if a patient selected a ten-minute slot, the call ended after ten minutes regardless of whether the consultation was finished or not. However, within the consultation itself, patients were clearly made aware when they were approaching the final minute of the consultation. They had the ability to extend the appointment times which would result in additional cost and this was demonstrated on the clinical system.

Tackling inequity and promoting equality

The provider offered consultations to anyone who requested and paid the appropriate fee. However, there was an element of potential discrimination to ensure that the service was safe and effective.

The provider chose to deliver a service only to English speaking patients. When we asked about this the provider's response was that it was important for them to be able to provide a safe, effective and responsive service and not to place patients at risk by way of ineffective and dysfunctional consultations which could happen because of language breakdown or poor communications. Immediately following the inspection and to ensure patients were made aware of this, the provider incorporated this information in to their sign-up terms and conditions.

Due to the limitations of their technology and to ensure that services did not place patients at risk, the provider did not support patients with impaired vision, deafness and/or impaired hearing. Immediately following the inspection, and to ensure patients were made aware of this, the provider incorporated this information in to their sign-up terms and conditions.

There was no information about the GPs on the website so that patients could choose who they wished to see. However, at the time of the inspection there was only one GP providing consultations.

Managing complaints

Although there was a comprehensive complaints procedure in place, there was limited signposting for patients and the escalation guidance within the policy was incorrect. Immediately following the inspection, the provider informed us they had updated the policy and removed any reference to the Parliamentary Ombudsmen Service. We saw this had been done.

The policy contained appropriate timescales for dealing with any formal complaint. Formal complaints had to be made in writing and all contact information was available within the policy. The provider was in the process of reviewing other external Independent advocacy services best suited for patient complaints of this type. They also added a complaints section to their website.

At the time of the inspection there had been no complaints received. We saw feedback received where one patient felt they had wasted their money and time for information they could have received easily elsewhere. The issue was because the patient had not provided the appropriate identification. However, we did not see any response or learning documented about this.

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 app had a set of terms and conditions and details on how the patient could contact

Good

Are services responsive to people's needs?

them with any enquiries. Information about the cost of the consultation was known in advance and paid for before the consultation appointment commenced. The costs of any resulting prescription or medical certificate were handled by the administration team at the headquarters following the consultation.

Patients automatically provided consent to AlldayDr's access to their medical records by accepting the terms and conditions. Patients were referred to the Privacy Policy if they wished to withdraw that consent. However, it was not obvious from the consultations that had taken place, that patients correctly understood this.

The consulting 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. 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 could be monitored through audits of patient records but we did not see that it had been. Patients under the age of 18 years were not able to use the service.

Requires improvement

Are services well-led?

We rated the service requires improvement in the well led domain because systems and processes were operating ineffectively. Systems to assess, monitor and identify the risks relating to patient safety in a digital environment were not effective and did not identify potential risks.

Business Strategy and Governance arrangements

The provider told us they had a clear vision to work together to provide a high-quality responsive service that put caring and patient safety at its heart. We discussed the objectives for the service in the next twelve months and the provider's strategy to improve and upscale the service. Future plans included upscaling the service specifically to a "Business to Business" model.

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 clear evidence of this immediately following the inspection where improvements were demonstrated, and policies updated because of discussions during the inspection process.

There were a variety of checks in place to monitor the performance of the service. Monitoring had included a check of all consultations, but the check was not independent as it was done by the provider who was also the consulting doctor. Discussions about the consultations had been held at team meetings and if improvements had been necessary, they had been made.

There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, the provider had not been aware of the risks identified by the inspection team for example in prescribing, questionnaires, identity checks and glitches in the clinical system.

Care and treatment records were securely kept. During the inspection we highlighted that clinicians should not wholly rely on the review of their video consultations and ensure that consultations were well documented. This was something that had already been identified by the service manager and improvement was on-going. We also highlighted that documented conversations taking place between patients and support staff were not recorded as contemporaneous notes. As a result of this being highlighted the provider has now adjusted policies and internal training and any chats on "fresh chat" will be copied and pasted in to the patient's record as an encounter.

Leadership, values and culture

The provider lead GP had overall responsibility of the running of the service and any medical issues arising. They attended the service daily and undertook all consultations. There were six managers and three administrators. We were told the provider was always available by telephone for any clinical enquiries. We were told that when the service was upscaled there would be other clinicians recruited to support the clinical management team.

The values of the service were to provide safe, effective and appropriate care in a digital environment.

Their mission was "to better empower individuals and provide a personalised solution to take better control of their health and wellbeing".

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.

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

Seeking and acting on feedback from patients and staff

Patients could rate the service they received. This was constantly monitored and if it fell below the provider's standards, this would trigger a review of the consultation to address any shortfalls. In addition, patients were prompted at the end of each consultation with a link to a survey they could complete, and they could also post any comments or suggestions online. Patients were asked to rate the doctor's

consultation and the service on a scale of 1-5 and to state whether they would recommend the service. We saw positive patient feedback was published on the service's website.

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

The provider had a whistleblowing policy in place. (A whistle blower is someone who can raise concerns about practice or staff within the organisation.) The provider lead GP 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 minutes of staff meetings where previous interactions and consultations were discussed.

Staff told us that the team meetings were the place where they could raise concerns and discuss areas of improvement regularly. However, as the management team and IT teams worked together at the headquarters there was always ongoing discussions about service provision.

There was a quality improvement strategy and plan in place to monitor quality and to make improvements, for example, through audit and discussion.

Innovation and Development

AlldayDr had their own Corporate Social Responsibility Scheme titled 'Health for Them & Us'. The clinical lead had previously worked with several charities in the developing world providing healthcare to those most in need. With the help of corporate clients and once the service is upscaled, the provider plans to offer healthcare to those in the developing world by sponsoring a consultation in the developing world for every consultation with an employee of a corporate client.

The provider's IT systems were provided by their own offshore IT team who were based outside of the UK. They had developed the website and apps for the varying Smart phone and tablet devices. The team provided technical support to the UK based customer service team throughout operational hours. The clinical system utilised Amazon Web Services (AWS) with industry standard technology as standard. All systems and staff were compliant in data protection and confidentiality.

The provider was working with the NHS and had obtained IM1 pairing accreditation. IM1 pairing is the process that allows suppliers to integrate their system with any principal clinical system through an interface mechanism. Interface mechanisms enable separate systems to read patient information, extract information in bulk and enter data in to the other system. This would provide GPs with complete information sharing (with patients' consent) and enhance effective outcomes by providing a full patient/GP to patient/GP experience.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and identify the risks relating patient safety in a digital environment.**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these. We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity	Regulation