Express Dispense Limited

Express Dispense

Inspection report

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Express Dispense Ltd on 13 February 2017. We found the service was not providing Safe, Effective and Well-led services in accordance with the relevant regulations. However, we found they were providing Caring and Responsive services in accordance with the relevant regulations.

Following the February 2017 inspection, we served a Warning Notice to the provider on the 2 May 2017 under Section 29 of the Health and Social Care Act 2008 which required the provider to become compliant by 2 June 2017. The full comprehensive report of the 13 February 2017 inspection can be found by selecting the 'all reports' link for Express Dispense on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 16 August 2017 to confirm that the provider had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection in February 2017. This report covers our review of the Warning Notice and findings in relation to those requirements.

Our key findings were:

- There were systems in place to confirm the patient's identity and ensure the resulting delivery of medicines was appropriate. However, these should be improved to ensure they are effective.
- There were systems in place to ensure staff had the information they needed to deliver safe care and treatment to patients, including national guidance such as Medicines and Healthcare products Regulatory Agency (MHRA) safety alerts, National Institute for Health and Care Excellence (NICE) guidance and General Medical Council (GMC) guidelines.
- The provider had a programme of ongoing quality improvement in place to monitor and improve the service provided to patients.
- There were processes in place to monitor the training needs of clinical staff and staff had received training relating to safeguarding, the Mental Capacity Act 2005 and duty of candour.
- The provider had formalised staff meetings to ensure all staff were regularly updated with service developments.
- All staff, including the GP and pharmacists, had access to all policies, including the safeguarding policy.

We found the provider had taken actions to make improvements to meet the requirements of the Warning Notice and was now providing safe, effective and well-led services in accordance with the relevant regulations.

Summary of findings

The areas where the provider should make improvements are:

- The provider should assure themselves that their process for verifying patient identity is effective given the nature of the format of their consultations.

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. However, the system of checks should be improved to ensure they are effective.
- There were systems in place to ensure staff had the information they needed to deliver safe care and treatment to patients, including Medicines and Healthcare products Regulatory Agency (MHRA) safety alerts.
- The provider was aware of and complied with the requirements of the Duty of Candour and encouraged a culture of openness and honesty.

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. There were systems in place to ensure staff had the information they needed to deliver safe care and treatment to patients, including national guidance such as National Institute for Health and Care Excellence (NICE) guidance and General Medical Council (GMC) guidelines.
- The service had a programme of ongoing quality improvement activity. For example, all transactions were reviewed monthly to analyse data and identify trends. This information, along with other feedback was used to improve service quality; and was discussed at staff meetings.
- 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.
- There were processes in place to monitor the training needs of clinical staff and appropriate staff had received training relating to the Mental Capacity Act 2005 and duty of candour. There were appropriate recruitment checks and records in place for all staff, including the GP.

Are services well-led?

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

- The provider had formalised staff meetings to ensure all staff were regularly updated with service developments; and meetings were minuted and had standard agenda items.
- All staff, including the GP and pharmacists, had access to all policies, including the safeguarding policy.
- The provider had reviewed systems and records for personnel files, including training records.

Express Dispense

Detailed findings

Background to this inspection

Background

Express Dispense Ltd was established in 2010 and registered with the Care Quality Commission in March 2016. Express Dispense operates an online clinic for patients via a website (www.expressdispense.com), providing consultations and both NHS and private prescriptions.

A registered manager is in place. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

How we inspected this service

Our inspection team was led by a CQC Lead Inspector accompanied by a GP specialist advisor.

Before visiting, we reviewed a range of information we hold about the service. During our visits we:

- Spoke with staff including the service manager, Superintendent Pharmacist, who is also the Registered Manager, and the principal GP.
- Reviewed organisational documents, including policies, staff personnel files and training records.

This inspection was an announced focused inspection to confirm that the provider had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection.

We asked the following three questions:

- Is it safe?
- Is it effective?
- Is it well-led?

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.

Are services safe?

Our findings

At our previous inspection on 13 February 2017, the provider was not providing safe services as we found:

- The provider did not ensure patients' identity was confirmed for each prescription and the resulting delivery of medicines was appropriate.
- The provider did not take due account of national guidance such as safety alerts issued by the Medicines and Healthcare products Regulatory Agency (MHRA) to ensure clinicians delivered evidence based healthcare and treatment in accordance with them.
- Processes were not in place to ensure staff have received relevant training including safeguarding to an appropriate level and the Duty of Candour.

These arrangements had improved when we undertook a follow up inspection on 16 August 2017. We found the service was now providing safe services.

Keeping people safe and safeguarded from abuse

At our inspection in February 2017 we found 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 GP and Superintendent Pharmacist had received adult and child safeguarding training to level two. The provider told us they would make arrangements for level three safeguarding training for these staff members.

At this inspection in August 2017, we spoke with staff about training and learning and saw records of safeguarding training certification at level three for the GP and Superintendent Pharmacist. All staff had access to safeguarding policies and could access information about who to report a safeguarding concern to.

Staffing and Recruitment

At our inspection in February 2017, we found the provider had a selection process in place for the recruitment of all staff. The provider kept records for all staff, however, they did not maintain a training record for the GP. We were not assured, from our interviews, that the GP was aware of the requirements of the Duty of Candour

At this inspection in August 2017, we found that the provider now had full HR file and training records for all staff, including the GP. We reviewed the file for the doctor and found it included records of training. For example, we saw records showing training had been completed on the duty of care, consent, safeguarding adults and information governance. We spoke to the GP who demonstrated he understood the Duty of Candour and was aware that when things went wrong, this would be explained to the patient, an apology would be offered and they would be advised of any action taken. We saw that the provider encouraged a culture of openness and honesty and saw standard agendas for monthly meetings that included discussion of complaints and significant events.

These arrangements demonstrated the provider was monitoring the training needs of clinical staff and appropriate staff had received relevant training, including safeguarding and Duty of Candour.

Prescribing safety

At our inspection in February 2017, we found the provider requested details of the patient's NHS GP as part of the registration process, however, it was not mandatory for patients to provide this information and this was an 'opt-out' system. We found there were protocols in place for identifying and verifying the patient. We saw evidence of a 'customer verification' standard operating procedure which instructed staff to check the patient identification with the BT Phone Book website and also to confirm the payment card matches the identity of the patient on the registration form.

At this inspection in August 2017, we found that the provider now required all patients to provide details of their NHS GP and checks were carried out to verify the proximity of the GP practice to the patient's address. No medicines were prescribed if GP details were not provided. The internet IP address of the patient was also logged and the computer system raised an alert if the patient had changed data in their recorded details. Further developments were being explored including requiring photographic ID and using independent, internet based, identity checks. The provider told us they would implement suitable arrangements in line with the expected publication of further CQC guidance.

These arrangements were in place to confirm the patient's identity and ensure the resulting delivery of medicines was

Are services safe?

appropriate. However, the provider should assure themselves that their process for verifying patient identity is effective, given the nature of the format of their consultations.

Management and learning from safety incidents and alerts

At our inspection in February 2017, we found there were systems in place to deal with medicines safety alerts. A nominated pharmacist received safety alerts and NHS notices for prescribing guidance via email and was responsible for disseminating these to relevant staff. However, the GP told us he had not received any safety alerts or NHS notices for prescribing guidance from the provider to date.

At this inspection in August 2017, we found safety alerts such as those issued by the Medicines and Healthcare products Regulatory Agency (MHRA) were received by the Superintendent Pharmacist who brought relevant ones to the attention of the GP and discussed these as necessary. We saw that relevant guidance, such as National Institute for Health and Care Excellence (NICE) guidance and General Medical Council (GMC) guidelines, were matched to each area of prescribing; and discussed at formal, monthly, minuted staff meetings.

These systems ensured staff had the information they needed to deliver safe care and treatment to patients, including national guidance and MHRA safety alerts.

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 13 February 2017, the provider was not providing effective services as we found:

- The provider did not take due account of national guidance such as National Institute for Health and Care Excellence (NICE) guidance and General Medical Council (GMC) guidelines to ensure clinicians delivered evidence based healthcare and treatment in accordance with them.
- There was no programme for quality improvement such as clinical audit to monitor and improve the service provided to patients.
- Processes were not in place to monitor the training needs of clinical staff and ensure appropriate staff have received training, including in the Mental Capacity Act 2005.

These arrangements had improved when we undertook a follow up inspection on 16 August 2017. We found the service was now providing effective services.

Assessment and treatment

At our inspection in February 2017, we found there was no system in place to assist the GP to assess patients' needs and deliver care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) evidence based practice. From our interview with the GP we were not assured that they had a comprehensive understanding of how to seek patients' consent to care and treatment, in line with the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005.

At this inspection in August 2017, we found there were systems in place to ensure staff had the information they needed to deliver safe care and treatment to patients, including national guidance such as NICE guidance and General Medical Council (GMC) guidelines. We saw standard agendas for monthly meetings that included, for example, discussion of NICE guidelines; and minutes of such meetings attended by the service manager, superintendent pharmacist and GP.

We found there were processes in place to monitor the training needs of staff, including the GP. There were records of appropriate training in place for all staff, including the GP and relevant staff had received training relating to the Mental Capacity Act 2005. We spoke with the GP who understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005.

These arrangements enabled the GP to seek patients' consent and utilise evidence based support tools to deliver care in line with current legislation, guidance and standards.

Quality improvement

At our inspection in February 2017, we found the service did not monitor consultations and carry out consultation and prescribing audits to improve patient outcomes. We saw no evidence of quality improvement.

At this inspection in August 2017, we found the service had a programme of ongoing quality improvement activity. For example, all transactions, both completed and failed, were reviewed monthly, to analyse data and identify trends. A new system had been added to the provider's website to capture patient feedback and we were told this was being published on the website. The monthly data and trend information, along with feedback from patients and other regulatory agencies, was used to inform a risk assessment process which was discussed at staff meetings. The GP had been involved in the development and updating of the feedback questionnaire. We saw standard agendas and minutes for monthly meetings that included discussion of clinical audits and recommendations. These meetings were attended by the service manager, Superintendent Pharmacist and GP. The provider told us they planned to carry out audits of best prescribing practice.

These arrangements enabled the service to monitor and improve the quality of patient outcomes.

Staff training

At our inspection in February 2017, we found there was no training record in place for all staff to identify when training was due. We were not assured that the GP had a comprehensive understanding of the Mental Capacity Act 2014 and they could not evidence this training. We found there was no monitoring in place for the training needs of the GP.

At this inspection in August 2017, we saw that the service manager had a comprehensive, electronic training matrix in place for all staff, including the GP. This identified

Are services effective?

(for example, treatment is effective)

mandatory and role specific training and when updates were due; and the provider was monitoring the training needs of all staff. Clear records, such as copies of certificates, were maintained in personnel files for each member of staff. For example, we saw evidence that appropriate staff, including the GP, had received training relating to the Mental Capacity Act 2005.

These arrangements enabled the provider to ensure staff had the skills, knowledge and competence to deliver effective care and treatment.

Are services well-led?

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

Our findings

At our previous inspection on 13 February 2017, the provider was not providing well-led services as we found:

- Staff meetings were not formalised to ensure all staff were updated with service developments regularly; and ensure all staff had access to policies.

These arrangements had improved when we undertook a follow up inspection on 16 August 2017. We found the service was now providing well-led services.

Business Strategy and Governance arrangements

At our inspection in February 2017, we found there was a range of service specific policies which had been developed, however, the GP was unaware of the existence of these. There had been no audits undertaken to analyse the overall operational performance of the service or clinical audits undertaken. There was no provision for clinical oversight for the GP and no clinical meetings held.

At this inspection in August 2017, we found all staff, including the GP and pharmacists, had access to all policies, including the safeguarding policy. We saw records that policies had been provided to the GP and evidence that the GP had read and understood them. We saw evidence that arrangements for clinical oversight and quality improvement were in place, being implemented and recorded.

The provider had formalised staff meetings to ensure all staff were regularly updated with service developments. We saw examples of standard agendas for minuted meetings that included discussion of clinical issues and evidence that these were attended by the service manager, Superintendent Pharmacist and GP. We saw from minutes of meetings where previous interactions and consultations were discussed. The provider had also reviewed systems and records for personnel files, including training records.

These arrangements ensured a comprehensive understanding of the performance of the service was maintained.

Leadership, values and culture

At our inspection in February 2017, we found there was a lack of engagement between the GP and the rest of the Express Dispense Ltd team. We were informed that team meetings were informal, irregular and not minuted. There was an open and transparent culture, supported by an operational policy regarding safety incidents, however, we were not assured that the GP was aware of Duty of Candour requirements.

At this inspection in August 2017, we found evidence of regular and full engagement between the GP and the service management team. We saw evidence of regular communication including formal, monthly, minuted meetings attended by the service manager, Superintendent Pharmacist and GP. We spoke to the GP who demonstrated their understanding of the Duty of Candour requirements.