Dr Morton's - The Medical Helpline

Inspection report

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Date of inspection visit: 27 September 2019
Date of publication: 03/12/2019

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

Ratings

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

Overall summary

Letter from the Chief Inspector of Primary Medical Providers and Integrated Care

We rated this provider as Good **overall.** (Previous inspection November 2017 – met all standards)

The key questions are rated as:

Are providers safe? – Good

Are providers effective? – Good

Are providers caring? – Good

Are providers responsive? – Good

Are providers well-led? – Good

We carried out an announced inspection at Dr Morton's - The Medical Helpline on 27 September 2019. The provider is an online GP and specialist gynaecology consultation service, UK-wide with headquarters in London. This inspection was part of the digital and online providers inspection programme to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. Patients register for the provider on the provider's website to either undergo a consultation or to select the medicines they require. Patients are required to complete an online questionnaire which is reviewed by a doctor.

At this inspection we found:

- The provider had good systems to manage risk so that safety incidents were less likely to happen. When they did happen, the provider learned from them and improved their processes.
- The provider routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- Staff treated people with compassion, kindness, dignity and respect.
- Patients could access care and treatment from the provider within an appropriate timescale for their needs.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- The provider did not have a system in place to check the symptoms of patients requesting a prescription through the provider's website. This feature was implemented after the inspection.

The provider carried out clinical audits of three telephone consultations per month at random, and three telephone consultations for each doctor as part of their assessment towards their structured reference at the time of their NHS-post appraisal. The areas where the provider **should** make improvements are:

- Continue to improve the process of obtaining patients' consent for the provider to contact their registered.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Providers and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a second CQC Inspector, a specialist adviser, and a member of the CQC medicines team.

Background to Dr Morton's - The Medical Helpline

Dr Morton's - The Medical Helpline offers patients medical advice and treatment via an online platform. Patients access the provider via Dr Morton's website and can request consultations with a doctor via email or telephone. The provider had other consultant specialists available to their doctors so that expert opinions can be delivered to patients when necessary. Patients can access the provider by registering through Dr Morton's website, via secure email or telephone. If felt useful or appropriate a video call may be offered to the patient via a web link. Patients pay for these services by monthly subscription, which offers an unlimited access for a set payment per month, or by paying for an individual consultation. Medicines can be ordered from a small selection available via the provider's website. The provider uses a fulfilment pharmacy that posts prescriptions to patients recorded delivery. Following the inspection, the provider informed us that they provided medical consultations and governance to a partner online pharmacy. We did not knowing review this aspect of their work.

Patients register with the provider by creating an account (username and password – they are not allowed to use an email address as their username) they are then required to complete a medical history form.

The provider employs staff that work from their registered address including a Chief Executive Officer, Senior independent non-executive director and the Medical Director. On average the provider handles 3100 consultations per month. The provider can be accessed through their website: www.drmortons.co.uk where registered patients can place orders for medicines seven days a week. The provider is available from 7am to 11pm, seven days per week, 356 days per year via telephone, email and video chat. Subscribers to the provider pay for their medicines when making their on-line application. Once approved by the doctor, medicines are supplied by the affiliated pharmacy.

The provider has a registered manager in place. A registered manager is a person who is registered with the CQC to manage the provider. Like registered providers, they are 'registered people. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the provider is run.

The provider is registered for the following registered activities: Treatment of disease, disorder or injury; Transport providers, triage and medical advice provided remotely.

How we inspected this provider

Before the inspection we gathered and reviewed information from the provider. During this inspection we spoke to the Registered Manager and members of the management 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.

Good

Are services safe?

We rated safe as Good :

Keeping people safe and safeguarded from abuse

Staff employed by the provider had received training in safeguarding and whistleblowing and knew the signs of abuse. All staff had access to the safeguarding policies and where to report a safeguarding concern. The provider had included a safeguarding app on their computer desktop for all staff to access. All the doctors had received adult and level three child safeguarding training. It was a requirement for the doctors registering with the provider to provide evidence of up to date safeguarding training certification.

Monitoring health & safety and responding to risks

The provider office housed the IT system and three members of staff. Patients were not treated on the premises as doctors 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.

There were systems to ensure patient confidentiality was maintained and that data was stored securely on the record system. There were processes in place to manage any emerging medical issues during a consultation and for managing test results and referrals.

Meetings were held with staff, where standing agenda items covered topics such as significant events, complaints, clinical updates, formulary and prescribing updates, audit feedback and policy updates. We saw evidence of meeting minutes to show where some of these topics had been discussed, for example finalising and implementing customer feedback automation. Although the provider had carried out audits of doctor consultations, we did not see evidence of case reviews for additional learning.

The provider expected that all doctors would conduct consultations in private and maintain patient confidentiality. Each doctor user was required to log into an encrypted, password secure laptop to log into the operating system, which was a secure programme. Doctors were required to complete a home working risk assessment to ensure their working environment was safe.

The provider was not intended for use by patients as an emergency provider. In the event an emergency did occur, the provider had systems in place to check the location of the patient at the beginning of the consultation, so emergency providers could be called. Callers were not able to receive a telephone consultation if they called the provider from a withheld number.

All clinical consultations were rated by the doctors for risk. For example, if the doctor 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 support team and clinical director. There were protocols in place to notify Public Health England of any patients who had notifiable infectious diseases.

Staffing and Recruitment

There were enough staff, including GPs and gynaecologists, to meet the demands for the provider. There was a support team, including consultants from all major specialities, available to the GPs during consultations and a separate IT team.

The provider had a selection and recruitment process in place 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 provider (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 doctor employees had to be currently working in the NHS (as a GP or gynaecologist as appropriate) and be registered with the General Medical Council (GMC) (if a GP, on the Performers list) with a license to practice. They had to provide evidence of having professional indemnity cover (to include cover for video consultations), an up to date appraisal and certificates relating to their qualification and training in safeguarding and the Mental Capacity Act.

Newly recruited doctors were supported during their induction period and an induction plan was in place to ensure all processes had been covered. We were told that doctors did not start consulting with patients until they had successfully completed one test scenario of a consultation.

We reviewed 18 recruitment files which showed the necessary documentation was available. The doctors could not be registered to start any consultations until these

checks and induction training had been completed. The provider kept records for all staff including the doctors and there was a system in place 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 and during a consultation were monitored by the provider to ensure prescribing was evidence based. If a medicine was deemed necessary following a consultation, doctors could issue a private prescription to patients.

The provider's website advertised 17 medicines available through the online prescription service. Doctors could only prescribe from this list for patients who chose that service. There were no controlled drugs on this medicines list. Once the patient selected a medicine, this was reviewed, and a set dosage was issued by a doctor, relevant instructions were given to the patient regarding when and how to take the medicine. This included the purpose of the medicine and any likely side effects and what they should do if they became unwell.

Doctors were restricted in their prescribing for patients who used the consultation service. The provider informed us that doctors were informed not to prescribe any medicines with street value or addictive properties, and they were not permitted to initiate treatment for long-term conditions such as hypertension or arthritis. These requirements were documented in the provider's prescribing policy. The provider carried out monthly audits to ensure these guidelines were adhered to. In addition, the provider informed us that doctors were instructed not to prescribe medicines more than three consecutive times to patients that used the online prescription service without contacting the patient for additional information. We did not see this requirement outlined in any of the provider's policies. However, there was no evidence in patient's records that doctors had prescribed medicines more than three consecutive times.

We saw that patients were prompted to update their medical history if they had not logged into their account for three months or longer. The provider informed us that when emergency supplies of medicines were prescribed, there was a clear record of the decisions made and the provider would contact the patient's regular doctor to advise them.

Patients who were prescribed off -license medicine were informed of any associated risks. (Medicines are given licences after trials have shown they are safe and effective for treating a condition. Use of a medicine for a different medical condition that is listed on their licence is called unlicensed use and is a higher risk because less information is available about the benefits and potential risks). Doctors had immediate access to the British National Formulary via a link on the provider's computer system. Medicines sent to patients were monitored through a secure delivery system which required a signature on delivery. Temporary addresses and post office boxes were not allowed to ensure that the correct person received the correct medicine.

The provider had recently stopped prescribing medicines to treat asthma due to the potential safety concerns and recent changes to guidance regarding treatments for conditions that required monitoring.

The website advertised medicines which were available and there were systems in place to prevent the misuse of these medicines. We saw measures were in place to monitor potential over-ordering. We were informed that the provider had a system in place to prevent duplicate accounts; however, we found that one patient had registered twice with the provider. A few days after the inspection, the provider provided details of the patient's consultations showing that the duplication was previously noticed and the notes from the previous consultation cut and pasted into the new record of clinical care. Doctors had access to the patient's previous records held by the provider. Repeat prescriptions were limited based on relevant guidance and clinical review of repeat prescribing.

The provider had low levels of antibiotic prescribing and encouraged good antimicrobial stewardship by only prescribing from a limited list of antibiotics which was based on national guidance.

The provider prescribed some unlicensed medicines, and medicines for unlicensed indications, for example for the treatment of morning sickness. The provider informed doctors, if they wished to prescribe such medicines it was essential they inform the patient of this fact and record that they had done so. We were informed that an additional paper notification was inserted by the pharmacist at the time of the medicine being dispensed to reinforce this

information. Doctors were required to document that they were satisfied that the patient had the mental capacity to understand the information, and if in doubt, they should not prescribe.

There was clear information on the consultation form to explain that the medicines were being used outside of their licence, and the patient had to acknowledge that they understood this information. Additional written information to guide the patient when and how to use these medicines safely was supplied with the medicine.

Information to deliver safe care and treatment

On registering with the provider, and at each consultation, the patient's identity was verified. The automated verification process included a search of multiple data sources, cross checking and verifying the name, age and address of the person. Where discrepancies were identified the patient was asked for further identification such as formal photographic identity in order to continue with their order. Accounts would not be activated, thereby allowing patients to request medicines, until identity verification was completed by the administrative team. An additional safeguard was the daily checking of any mismatch between the account name, email address and payee's details. We saw an example when the provider had identified mismatches between the payee and account holder's name. These were investigated to establish what, if any, relationship the payee had to the patient.

Management and learning from safety incidents and alerts

There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. These were discussed in meetings and staff received information regarding any learning. We saw evidence from incidents 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. National Institute for Health and Care Excellence guidelines and safety alerts were circulated to doctors in the weekly 'roundup' letter; although urgent serious alerts were communicated immediately by the director of quality and governance to all doctors.

Good

Are services effective?

We rated effective as Good :

Assessment and treatment

We reviewed seven examples of medical records that demonstrated that each doctor 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. However, we did identify areas for improvement; one of the consultations showed that a patient was initiated on and given a three-month prescription based on test results that were submitted by the patient, the results were not uploaded to the system (the doctor had not seen the actual results and was relying on the information given by the patient). After this the patient had not updated their medical record to reflect the new medicine and were subsequently prescribed two sets of 3 months prescriptions.

Patients completed an online form which included their past medical history. There was a set of templates 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 noted that the online prescription service did not require patients to provide information about their current symptoms. Therefore, there was a risk that medicines would be prescribed to people inappropriately. We raised this with the provider and was shown evidence this had been identified, and steps had been taken to develop an online feature which would allow patients to detail their symptoms when ordering a prescription. A week following the inspection, the provider forwarded evidence that this feature was fully operational, and patients were able to add information relating to their symptoms.

If the patient had not updated their medical history within three months they were prompted to do so, after which they would be able to purchase a prescription from a list of conditions on the provider's website. Once the patient had clicked to purchase they were informed that a doctor would review their notes and either action the prescription or contact them for further details. We discussed this with the provider and were assured that they had identified the potential risks and were in the process of implementing an additional section to be completed by patients on symptoms.

The doctors working for the provider 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 clinical tool available to doctors for clinical assessment provided a drop-down list of medication relevant to the condition selected. We were told that, if the provider could not deal with the patient's request, this was explained to the patient and a record kept of the decision.

Quality improvement

The provider monitored consultations and carried out consultation and prescribing audits and monitored information on patients' care and treatment outcomes to improve patient outcomes. At the end of every month a list of all medicines was reviewed in the quality assurance meeting to check appropriateness.

Examples of quality improvement activity were:

- A review of the safety in relation to updated guidance regarding the prescribing of asthma medication led to the removal of treatments for this condition.
- An audit of email communications in June 2019 which led to the action, to draw to the attention of the board the value of increasing the hours of coverage by gynaecologists.

We found the computerised clinical record system enabled responsive audit of prescribing generated through consultations. However, the provider had not identified means of proactively auditing prescribing through the online prescription service. There were no direct risks identified during the inspection as a result of this. We saw evidence that the provider was proactively identifying and responding to potential prescribing concerns.

Staff training

All administrative staff completed Level 1 safeguarding training as part of their induction and all Doctors had to have completed Level 3 child safeguarding and adult safeguarding training and mental health capacity act 2015 before starting work with the provider. Doctors were also

required to complete a registration form which included questions on what they would do in a set of emergency situations. The provider had a training matrix which identified when training was due and completed.

The doctors registered with the provider received specific induction training prior to treating patients. Doctors were required to undergo one role-play before being able to carry out consultations. An induction log was held in each staff file and signed off when completed. Supporting material was available, for example, a doctor's handbook, how the IT system worked and aims of the consultation process. There was also a newsletter sent out when any organisational changes were made. The doctors told us they received excellent support if there were any technical issues or clinical queries and could access policies. When updates were made to the IT systems, the doctors received further online training.

- All doctors had to have received their own NHS appraisals before being considered eligible at recruitment stage. All doctors had specific assessments as part of the preparation of a 'structured reference' for their NHS annual appraisal. Appraisal dates were recorded and monitored along with the doctors GMC number. The provider did not appraise the doctors that worked at the service.

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.

We reviewed eight patients records and found that all, but one patient did not have consent to share details of their consultations with their registered GP recorded. The provider had taken steps to ensure doctors requested consent on each occasion by measuring this through consultation audits. This was also addressed during the provider's quality and governance committee meetings and in the weekly roundup letters to doctors.

The provider had identified medicines required for fertility treatment as 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. We saw that doctors encouraged patients to give consent for their GP to be contacted and were audited against this measure, but this did not prohibit the doctor from prescribing. Where patients agreed to share their information, we saw evidence of letters sent to their registered GP in line with GMC guidance. Of the seven consultations we reviewed one did not contain information on whether the patient had given GP consent.

The provider did not make NHS hospital referrals; if a patient wished to self-pay doctors would write the referral letter and store it in the patient's portal for downloading and printing by the patient. Doctors were prompted by the system to confirm that the referral letter had been written and saved. The letter stated that correspondence should be sent to the patient's registered GP.

Supporting patients to live healthier lives

The provider identified patients who may need extra support and had a range of information available on the website (or links to NHS websites or blogs). For example: the benefits of a Mediterranean diet and benefits of cervical screening. In their consultation records we found patients were given advice on healthy living as appropriate.

Good

Are services caring?

We rated caring as Good :

Compassion, dignity and respect

We were told that the doctors undertook online, video and telephone consultations in a private room and were not to be disturbed at any time during their working time. The provider carried out clinical audits of three telephone consultations per month at random, and three telephone consultations for each doctor as part of their assessment towards their structured reference at the time of their NHS-post appraisal. Email consultations were audited for quality within a three -monthly cycle. Feedback arising from these spot checks was relayed to the doctor. We were told that any areas for concern would be followed-up and the doctor would again be reviewed to monitor improvement.

We did not speak to patients directly on the day of the inspection. However, we reviewed four surveys from the proceeding months. At the end of every consultation, patients were sent an email asking for their feedback. Patients that responded (eleven) in August 2019, indicated they found the doctors very helpful, polite, and that they made them feel listened to, and that they would recommended the provider to a friend or family member. 73% of respondents said that they were very satisfied with the provider overall. The remaining 27% said they were satisfied with the provider overall. 100% said they would recommend the provider to a friend or family member.

Involvement in decisions about care and treatment

Patient information guides about how to use the provider and technical issues were available. There was a dedicated team to respond to any enquiries.

Patients had access to information about the doctors working for the provider and could book a consultation with a doctor fulfilling certain criteria. For example, whether they wanted to see a male or female doctor. The provider told us that the provider did not have a translation provider for patients that do not speak English, this was being looked into.

Patients could have a copy of their video consultation only if they made a written request for a copy of the recording to the provider.

Good

Are services responsive to people's needs?

We rated responsive as good:

Responding to and meeting patients' needs

Consultations were provided seven days a week, between 7am and 11pm, and access via the website to request a consultation was all day every day. We were told that consultations were not time restricted. If the doctor had not reached a satisfactory conclusion during a consultation there was a system in place where they could contact the patient again. This provider was not an emergency provider. 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 already registered patients to contact the provider from abroad, but all medical practitioners were required to be based within the United Kingdom. Any prescriptions issued were delivered within the UK to the patient's address. There was information including videos available on the website to demonstrate how the provider operated. The website made it clear to patients what the limitations of the provider were.

Patients could request a consultation with a specific doctor by asking through the secure email when the clinician was next available. There was no maximum length of time for a consultation. Medicines supplied were monitored through a secure delivery system which required a signature on delivery. The in-house survey completed in August 2019 identified that 100% of patients were satisfied with the time it took to deliver their prescriptions.

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 doctors available. Patients could choose either a male or female doctor or one that spoke a specific language or had a specific qualification. Type talk was available.

Managing complaints

Information about how to make a complaint was available on the provider's web site. The provider had developed a complaints policy and procedure. The policy contained appropriate timescales for dealing with the complaint. There was escalation guidance within the policy. A specific form for the recording of complaints had been developed and introduced for use. We reviewed the complaint system and noted that comments and complaints made to the provider were recorded. We reviewed all the six complaints received in the past 12 months.

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

Consent to care and treatment

There was clear information on the provider's website with regards to how the provider 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. In addition, the website had a 'News' section which contained recent posts from consultants on an array of subject such as contraception. 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 following the consultation.

All doctors and 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.

Good

Are services well-led?

We rated well-led as Good :

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. They informed us they wanted to grow sustainably and enable a safe model based on quality.

There was a clear organisational structure and staff were aware of their own roles and responsibilities. There was a range of provider specific policies which were available to all staff. These were reviewed annually and following incidents, publication of new relevant guidance, and patient feedback when necessary.

There were a variety of checks in place to monitor the performance of the provider. The information from these checks was discussed daily and was used to produce a clinical monthly team report that was discussed at monthly team meetings. This ensured a comprehensive understanding of the performance of the provider was maintained. 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 proprietor of the company had overall responsibility as CQC registered manager and was supported by the chief executive officer and senior independent non-executive director. There was also a director of quality and governance and chief financial officer. The administrative and support team included an IT manager, a director of quality and governance and a customer services manager, and systems architect. They were clear on their roles and responsibilities and enabled to undertake their lead roles.

The provider had an open and transparent culture. We were told that if there were unexpected or unintended safety incidents, the provider would give affected patients reasonable support, truthful information and a verbal and written apology. This was supported by 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 provider could provide a clear audit trail of who had access to records and from where and when. The provider had an up to date registration 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 were invited to provide feedback on the service they received by being emailed a link to questionnaire to complete. The results were monitored monthly and if they 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. Data presented to us indicated positive experiences overall from patients. Questions related to ease of registering with the provider, whether patients felt listened to by the doctor and overall satisfaction with the provider.

There was evidence that the doctors 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.) A non-executive director and member of the Quality and Governance committee is the named Freedom to speak up Guardian.

Continuous Improvement

The provider consistently sought ways to improve. All staff were involved in discussions about how to develop services and were encouraged to identify opportunities to improve. We saw from 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 monthly. However, as the management team and IT teams worked together at the headquarters there was ongoing discussions at all times about provider provision.