Online Clinic (UK) Limited

Online Clinic (UK) Limited - Taybridge Road

Inspection report

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Online Clinic (UK) Limited – Taybridge Road on 21 March 2017.

This service operates two websites that offer online medical services; www.theonlineclinic.co.uk and www.privatedoctordirect.com. On the day of our inspection, the provider's statement of purpose was not up to date; only one website was mentioned within the statement of purpose and this did not detail all addresses involved in the provision of services. The service only provides services to patients aged over 18 years old and to patients within the UK.

Both websites allow patients to request treatment for a range of specific conditions; this request is reviewed by a doctor (not all of the doctors working for Online Clinic (UK) Limited were GPs), who then prescribed a medicine to treat the condition. This medicine is dispensed by a third party pharmacy and delivered by an external courier service.

We found this service did not provide safe, effective, responsive or well led services in accordance with the relevant regulations. The service did provide caring services in accordance with the relevant regulations.

Our key findings were:

- Systems were in place to protect personal information about patients. The company was registered with the Information Commissioner's Office.
- At the time of our inspection there was no system in place to verify a patient's identity. We were informed the provider was arranging for a system to be put in place.
- There were no systems in place to deal with the event of a medical emergency whilst a patient was in contact with the service provider. The service did not have a business contingency plan.
- Patient consultations and prescribing decisions were monitored informally by a non-clinician at the time of our inspection; however, we have been told that some prescribing decisions were peer reviewed by a second clinician. We were also told a clinical lead had recently been appointed and this member of staff intended to conduct reviews in the future.
- There was no overarching clinical governance system in place to ensure the delivery of safe and effective care. A clinical lead had recently been appointed and intended to improve clinical governance.
- We were not assured that patient consultation records were always accurate or complete. We were not

Summary of findings

assured that patients were treated in line with best practice guidance. We spoke with two clinicians, one was not aware of the 'Good practice in prescribing and managing medicines and devices' Guidance produced by the General Medical Council.

- There was no effective system in place to ensure safety or medicines alerts were received, understood or actioned by all relevant staff.
- Clinical staff we spoke with had a limited insight into the way services were provided, of other staff within the organisation and of other staff member's roles and responsibilities.
- There were limited, informal systems in place to mitigate safety risks including analysing and learning from significant events and safeguarding. There was no significant event policy and limited information relating to previous incidents. There was no formal safeguarding lead in place at the time of our inspection and records of staff attendance at safeguarding training were incomplete.
- There were appropriate recruitment checks in place for all staff; however training records were incomplete and did not assure the provider that staff had completed appropriate training.
- Not all policies reflected current practice; for example, the provider's consent policy did not align with the process for gaining consent in place at the time of our inspection.
- Limited information about how to complain was available on the websites.
- The provider was aware of and complied with the requirements of the Duty of Candour.
- The service encouraged and acted on feedback from patients via a third party review website, we saw evidence of actions taken in response to this feedback. Feedback via this website reported that patients felt they were treated with compassion, dignity and respect.
- The provider had prepared a business plan for the purpose of our inspection outlining plans for additional services and recruitment. We saw no evidence of this having been shared or discussed with staff.

The areas where the provider must make improvements are:

- Ensure the safety of patients by having appropriate systems to manage incidents, safety and medicines alerts, consultation forms, prescribing, patient consent and identity verification, safeguarding and business continuity.
- Ensure the quality of the service by having appropriate clinical leadership and governance strategies including up to date policies and protocols available for all staff, training, quality assurance monitoring and learning from complaints.
- Ensure all staff are aware of the 'Good practice in prescribing and managing medicines and devices' and evidence based guidance when deciding how to protect patients from the risk of unsafe prescribing of medicines.
- Implement and embed a system of quality improvement, such as clinical and non-clinical audits.

We have taken urgent action in response to the concerns identified at Online Clinic (UK) Limited; we have suspended the provider's registration until 22 June 2017.

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 not providing safe care in accordance with the relevant regulations.

- There were systems in place to protect all patient information and ensure records were stored securely. The service was registered with the Information Commissioner's Office.
- There were no systems in place to deal with the event of a medical emergency whilst a patient was in contact with the service provider. The service did not have a business contingency plan.
- There was no system in place to verify a patient's identity; the provider had a plan in place to implement a system of identification verification.
- Prescribing was not formally monitored and consultations were not being audited or monitored for any risks, although the provider had plans to start this process.
- There was no significant event or serious incident policy. We saw evidence of three incidents having been recorded in brief but there was no system in place to ensure these were investigated, shared or learned from.
- The provider was aware of and complied with the requirements of the Duty of Candour and adopted a culture of openness and honesty.
- There were enough GPs to meet the demand of the service and appropriate recruitment checks for all staff were in place. There were six doctors working for the organisation; four were GPs, one was a doctor not on the GP register, one doctor was not a GMC registered doctor who was not UK based; we were told this doctor did not consult with patients and only authorised prescriptions. However, the provider's websites stated that all clinicians are GMC registered GPs.
- The provider did not have evidence of all staff having completed safeguarding training appropriate for their role. There was no formal safeguarding lead in place although staff told us they would pass any concerns to the Registered Manager. There was a safeguarding policy available with local authority information for the locality of the provider's office address if safeguarding referrals were necessary; however the clinicians we spoke with were not aware of this policy.
- There were systems in place to meet health and safety legislation.

Are services effective?

We found that this service was not providing effective care in accordance with the relevant regulations.

The patient's identification was not checked at every consultation or when prescriptions were issued, the provider had a plan in place to implement this.

- Consent to care and treatment was sought during the online request for treatment and this was a compulsory step in order to proceed with the consultation and order. The consent policy did not reflect this process as it had not been updated since the alteration in the online system. The provider was not able to evidence that all clinical staff had undertaken training about the Mental Capacity Act.
- We were told that provider assumed each doctor took responsibility for assessing patients' needs and delivered care in line with relevant and current evidence based guidance and standards, for example, National Institute for

Summary of findings

Health and Care Excellence (NICE) best practice guidelines. However, we reviewed a sample of consultation records and found that they did not always demonstrate appropriate record keeping and patient treatment. Not all clinical staff we spoke with were aware of 'Good practice in prescribing and managing medicines and devices' Guidance produced by the General Medical Council.

- There was no system in place for ensuring safety alerts were received, reviewed and actioned if necessary.
- The provider's operating system allowed over-writing in patient records which did not ensure that clinicians had a full awareness of the patient history. The provider has taken some action in response to this finding since our inspection.
- The service had arrangements in place to share information appropriately with a patient's GP if the patient gave consent.
- If the provider could not deal with the patient's request, this was explained to the patient and a record kept of the decision.
- The service's web site contained information to help support patients lead healthier lives, there was also an online forum on the provider's website to enable patients to discuss common complaints and treatment choices.
- There were no formal induction or training arrangements in place to ensure staff had the skills, knowledge and competence to deliver effective care and treatment. The provider had a record of the clinical appraisals the doctors had completed and non-clinical staff told us they had received an in-house appraisal.

Are services caring?

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

- Systems were in place to ensure that all patient information was stored and kept confidential.
- We were told that GPs undertook consultations in private; however no checks had been undertaken by the provider to ensure this was the case.
- We did not speak to patients directly on the days of the inspection. The service is registered on an online review website. At the time of our inspection the service was rated, on the online review website, as excellent and had scored an overall score of 9.8 out of 10 from over 3,000 reviews. At the end of each consultation patients were sent an email asking for feedback.

Are services responsive to people's needs?

We found that this service was not providing responsive care in accordance with the relevant regulations.

- There was information available to patients to demonstrate how the service operated. Patients could access help from the service.
- Patients were able to access services through the website 24 hours a day, seven days a week. Whilst a next day service was guaranteed for orders placed Monday to Friday, we were told that clinical staff monitored orders over the weekend and aimed to action these on the same day.
- The provider's website gave the names and GMC registration number of four out of the six doctors that worked for the service.
- There were no translation services available for patients who did not have English as their first language as the provider deemed this to be unnecessary; one clinician we spoke with told us they would use an online translation tool if needed.

Summary of findings

- There was a complaints policy which provided staff with information about handling formal and informal complaints from patients. There was limited information available on the website.

Are services well-led?

We found that this service was not providing well-led care in accordance with the relevant regulations.

- The provider had written a brief outline of plans for the future of the business in response to our inspection, we saw no evidence to demonstrate this had been discussed or shared with staff. There was no overarching governance framework to support clinical governance and risk management although the provider had attempted to manage risk and governance on an informal basis.
- There was a staff structure in place and the staff we spoke with understood their own responsibilities but were not aware of other staff member's responsibilities. Staff were aware of the organisational ethos and they told us they felt well supported and could raise any concerns with the provider or the manager.
- Staff working remotely had very little engagement with the provider, were not always aware of current issues or changes within the organisation and did not have online access to policies unless they were requested by email.
- The service received patient feedback from an online review website. Staff told us they felt they could feedback about the service, but that this was done informally.
- The provider had carried out a two cycle clinical audit as part of its quality improvement activity. There was a 12 month plan in place to drive quality improvement over the next year. The provider had also taken action in response to their risk assessment of patient safety topics.

Online Clinic (UK) Limited - Taybridge Road

Detailed findings

Background to this inspection

Background

Online Clinic (UK) Limited was registered with the Care Quality Commission on 1 October 2010. The service offers patients' online consultations for a condition selected by the patient themselves. A doctor will then review the request, may ask for further information and then, if appropriate, provide a private prescription to be dispensed by a third party pharmacy. The services are accessed via two websites run by the provider; www.theonlineclinic.co.uk and www.privatedoctordirect.com.

At the time of our inspection there were six clinicians working for the service. Five of these clinicians were UK based GMC registered doctors. One clinician was not a UK based, GMC registered doctor and we were told this doctor only authorised prescriptions and did not consult patients. We were told by the Registered Manager that a clinical lead had recently been appointed.

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.

Our inspection team was led by a CQC Lead Inspector accompanied by a second CQC Inspector, a CQC Pharmacist Specialist and two CQC GP Specialist Advisors.

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew.

During our visits we:

- Spoke with a range of staff
- Reviewed organisational documents
- Patient consultations/orders

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

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

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.

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

Are services safe?

Our findings

We found that this service was not providing safe care in accordance with the relevant regulations.

Safety and Security of Patient Information

The provider made it clear to patients what the limitations of the service were. There were insufficient processes in place to manage any emerging medical issues during a consultation; if, when using the website, patients selected complaints relating to a chest disorder the website did provide advice informing patients they should see a doctor face to face. The service was not intended for use as an emergency service.

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. The service was registered with the Information Commissioner's Office.

At the time of our inspection there were no systems in place to verify a patient's identity. The provider had plans to implement a system as soon as possible. The service did not offer treatment to children although due to the absence of identity checks we could not be assured this was always the case.

Prescribing safety

Medicines prescribed to patients following an online consultation were not adequately monitored by the provider to ensure prescribing was evidence based. If medicine was deemed necessary following a consultation, the GPs were able to issue a private prescription to patients. The service's website advertised that opioid based medicines were available and the provider had recently implemented a system to prevent the misuse of this medicine; however there was no monitoring in place to ensure these systems were always effective and the provider was unable to tell us when the change in procedure had occurred or evidence how these changes were communicated to staff. We saw examples of patient consultations which demonstrated that this system was not always effective as patients were able to order different types of opioid medicines to avoid the limitation on ordering large quantities of the same medicine. The provider took action on the day of our inspection to prevent this happening again; however, we did not see how this was communicated to staff.

Once the GP selected the medicine and dosage of choice, a third party pharmacy dispensed the medicine and provided relevant instructions to the patient regarding when and how to take the medicine, the purpose of the medicine and any likely side effects and what they should do if they became unwell. We noted that medicines were prescribed for unlicensed indications, for example to treat premature ejaculation. Medicines are given licences after trials have shown they are effective and safe for use in treating a particular disease. If a medicine is used in a way that is different from that described in its licence, this is called 'unlicensed' use. Treating patients with medicines for a disease that is not described in its licence poses a higher risk because less information is available to show the benefits and less is known about the potential risks. The manufacturer's patient information leaflet provided with medicines only refers to the licensed use of that medicine. We saw that in some cases the patient was not informed that the medicine they were requesting was being used outside of its licensed indications.

There was no system in place to ensure patients taking long term medicines for conditions such as asthma or blood pressure were being adequately monitored. We saw examples of antibiotic prescribing which did not demonstrate effective antibiotic stewardship.

We were not assured that suitable checks were made to ensure medicines were safe to prescribe. We saw examples of prescribing outside of national guidance which may expose patients to unnecessary treatments or, in some cases, delay the patient receiving effective treatment or investigations.

Prescriptions were dispensed and dispatched by a third party pharmacy; patients were not able to request an alternative pharmacy. Medicines were delivered by a third party courier and were tracked and signed for on delivery.

Management and learning from safety incidents and alerts

There were no effective systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. There was no policy relating to significant events or safety incidents. The

provider had identified three incidents; these were recorded in brief; there was insufficient detail to demonstrate that appropriate actions had been taken or that these incidents had been shared or discussed with staff.

There were no effective systems in place to deal with medicine safety alerts. We were told the provider received alerts; a non-clinical member of staff assessed the relevance of these safety alerts and would share the information if needed.

Safeguarding

There was limited evidence of staff training in safeguarding. The provider only had evidence of two clinicians having safeguarding training. One clinician we spoke to was unable to demonstrate an understanding of safeguarding specific to treating patients via a digital platform. There was a safeguarding policy in place although there was not a named safeguarding lead; staff assumed it was the managing director who was not a clinician. Staff working remotely did not have online access to policies unless they requested them via email.

The provider only had evidence of one clinician having received training about the Mental Capacity Act 2005; however staff we spoke with had a basic understanding of the Mental Capacity Act 2005. The provider's policy provided advice on assessing capacity and there was a capacity assessment form and best interest decision form available.

Staffing and Recruitment

There were enough staff, including GPs, to meet the demand of the service. There was no rota for clinical staff and availability was ad-hoc; however the provider ensured there was always a clinician available. The managing director, assistant and IT manager offered non-clinical support to the doctors in their role.

The provider had a selection process in place for the recruitment of all staff. Required recruitment checks were carried out for all staff prior to commencing employment.

Potential clinical candidates had to be registered with the General Medical Council (GMC) and had their appraisal. We were made aware of a clinician working for the service who was a non-UK based doctor who was not registered with the GMC, we were told this doctor did not consult with patients and only authorised prescriptions. Those clinical candidates that met the specifications of the service then had to provide documents including their medical indemnity insurance, proof of registration with the GMC, references, and proof of identification. We reviewed five recruitment files which showed the necessary documentation was available. However training records were incomplete and there was no effective system to monitor staff training.

Monitoring health & safety and responding to risks

At the time of our inspection arrangements for risk monitoring had been informal; however the provider had recently conducted a risk assessment to identify areas of high risk within the service provision and planned to audit and action these areas within the 12 months following our inspection.

Clinical consultations were not being formally reviewed by a clinician at the time of our inspection; a doctor had recently been appointed as a clinical lead and planned to review and audit consultation records and prescribing decisions.

The provider's CQC registered premises were not inspected on the day of our inspection due to building works. We visited an office where non-clinical staff were based which housed the IT system, management and administration staff. Patients were not treated on the premises and GPs carried out the online consultations remotely usually from their home. There was no evidence that administration staff had received training in health and safety including fire safety.

The provider expected that all GPs would conduct consultations in private and maintain the patient's confidentiality; however there was no system in place to check this.

Are services effective?

(for example, treatment is effective)

Our findings

We found that this service was not providing effective care in accordance with the relevant regulations.

Consent to care and treatment

There was information, including a patient's guide, on the service's website with regards to how the service worked and what costs applied. The website had a set of terms and conditions and details on how the patient could contact them with any enquiries. The patient consultation was free of charge; costs were only incurred if a prescription was issued.

Staff understood and sought patients' consent to care and treatment in line with legislation and guidance. Patients needed to provide consent via the website during the consultation and ordering process. The process for seeking consent was not monitored through patient records audits.

Assessment and treatment

We reviewed approximately 70 medical records. These records did not always demonstrate that each clinician 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 guidelines or 'Good practice in prescribing and managing medicines and devices 2013' Guidance produced by the General Medical Council.

We were told that there was no time restriction on each online consultation and that if the clinician had not reached a satisfactory conclusion there was a system in place where they could contact the patient back.

Patients completed an online form which included their past medical history. There was a set template to complete for the consultation which related to their chosen condition and included the reasons for the consultation and the outcome to be manually recorded, along with any notes about past medical history and diagnosis. The medical records we reviewed did not always demonstrate that notes had been adequately completed or that clinicians always recorded their rationale for prescribing. Clinicians had access to previous notes; however we found these records could be over-written and clinicians were not always able to see the changes made. The provider has taken some action in response to this finding since our inspection.

The doctors providing the service were aware of both the strengths (speed, convenience, choice of time) and the limitations (inability to perform physical examination) of working remotely from patients. If a patient needed further examination they were signposted to an appropriate agency. If the provider could not deal with the patient's request, this was adequately explained to the patient and a record kept of the decision.

There was no system to monitor consultations or to carry out consultation and prescribing audits to improve patient outcomes; however the provider told us of plans to implement a programme of audits over the following 12 months.

Coordinating patient care and information sharing

When a patient contacted the service they were asked if the details of their consultation could be shared with their NHS GP. If patients agreed we were told that a copy of the consultation notes would be shared with the GP. We were told that patients ordering opioid based medicines had to provide their GP details and that the GP would always be made aware of the medicines prescribe via the website; patients not giving their GP details could receive only a one off prescription for a small quantity (10 days' supply). This system had recently been implemented.

Supporting patients to live healthier lives

The service had a range of information available on the website relating to common health problems and lifestyle advice. The website also had an online forum to enable patients to discuss medical or health concerns.

Staff training

There was a policy which outlined mandatory training, such as health and safety and fire safety that all staff had to complete; however this training had not been completed at the time of out inspection. Not all staff could evidence training in safeguarding relevant to their role. There was no effective system, such as a training matrix, in place to monitor staff training or to identify when training was due.

Are services effective?

(for example, treatment is effective)

Staff who worked remotely received limited training specific to the service; when we spoke to clinical staff we found there was limited understanding of how the service operated and limited awareness of who else worked for the service.

Administration staff received annual performance reviews. All clinicians had to have received their own appraisals via the NHS appraisal system.

Are services caring?

Our findings

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

Compassion, dignity and respect

Systems were in place to ensure that all patient information was stored and kept confidential.

We were told that clinicians undertook consultations in private and fitted the consultations around their availability. The provider had not carried out random spot checks to ensure GPs were complying with the expected service standards.

The service is registered with an online review website; the service was rated, on the review website, as excellent and scored 9.8 out of 10 from over 3000 reviews. The provider monitors these reviews and had responded to any negative reviews left. The provider had not conducted specific patient satisfaction surveys.

Involvement in decisions about care and treatment

A patient information guide about how to use the service was available. There was a dedicated member of staff available to respond to any enquiries.

Patients had access to limited information about some of the clinicians available. The website provided the name and GMC registration number of four of the six doctors who worked for the service. Patients were treated by the clinician available at the time of their request.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We found that this service was not providing responsive care in accordance with the relevant regulations.

Responding to and meeting patients' needs

Patients were able to access the website and request a consultation at all times. The availability of clinicians was not documented in a rota system. We were told clinicians were available Monday to Friday between 9am and 5pm and that clinicians were often available outside these times, including weekends; however this was an informal arrangement. This service was not an emergency service.

We were told the service only treated patients located within the United Kingdom and medicines were only dispensed and dispatched to patients and addresses within the UK.

Patients requested an online consultation with a clinician who contacted them online via a messaging service. We were told there was no restriction of the length of a consultation and that clinicians were able to contact the patient to request further information.

Tackling inequity and promoting equality

The provider offered consultations to anyone who stated they were aged over 18 years of age and did not discriminate against any client group.

Patients could only access limited details of some of the clinicians available. There was not a system in place to enable patients to choose either a male or female clinician or one that spoke a specific language or had a specific qualification. Translation services were not available for patients who did not have English as their first language as the provider had deemed this to be unnecessary.

Managing complaints

Limited information about how to make a complaint was available on the service's websites. The provider had a complaints policy and procedure available to staff. The policy contained appropriate timescales for dealing with the complaint. There was escalation guidance within the policy. We reviewed a log of complaints which the provider deemed to be informal. The provider had not held any staff meetings to discuss complaints or reviewed complaints to identify trends.

Are services well-led?

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

Our findings

We found that this service was not providing well-led care in accordance with the relevant regulations.

Business Strategy and Governance arrangements

The provider told us they aimed to provide a high quality responsive service that put caring and patient safety at its heart. We reviewed a business plan that had been prepared for the purpose of the CQC inspection; this plan described aspirations for the future of the provider and new services being considered in addition to plans to recruit additional clinical staff; we saw no evidence of this having been discussed or shared with staff.

There was a staffing structure and staff were aware of their own roles and responsibilities; however staff had a very limited insight into the roles and responsibilities of other staff. There was a range of service specific policies which were available to all staff; however these were only available to staff working remotely if requested by email.

There was no formal programme of daily, weekly or monthly checks in place to monitor the performance of the service. We were told the registered manager, who is not a clinician, monitored patient consultations and prescribing on an on-going informal basis. We were also told of plans to implement a more formal programme of monitoring in the future.

The provider had a risk assessment highlighting areas which the provider planned to audit and action in the future; at the time of our inspection, these audits and actions had not been commenced.

Care and treatment records were legible and securely kept; however we were not assured that they were always complete or accurate.

Leadership, values and culture

At the time of our inspection, the Registered Manager, who was not a clinician, had overall responsibility. We were informed that a GP had been recently appointed as a clinical lead and would take responsibility for any medical issues arising.

We spoke with two clinicians who worked remotely and they did not have a thorough insight into the way the service operated and had minimal engagement with other clinical staff working for the provider.

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.

Seeking and acting on feedback from patients and staff

The provider utilised a third party review website to gather patient feedback. We saw evidence of actions taken in response to negative feedback.

There was limited evidence to demonstrate that GPs were able to provide feedback about the quality of the operating system. We were told by two clinicians that there was limited engagement between clinicians and between the clinical and non-clinical staff. Clinicians we spoke with told us they would report any concerns to the Registered Manager; however there was no evidence of concerns being shared.

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 Managing Director was the named person for dealing with any issues raised under whistleblowing.