MSF Medical Services Limited

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Inspection report

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at MSF Medical Services on 8 May 2017.

MSF Medical Services provides prescribing services to two online pharmacies (Assured Pharmacy and Mens Pharmacy). The service is run by a GP (who is the registered manager) who provides the prescribing service along with two additional GPs who are contracted by MSF and work remotely. GPs from MSF have access to the online systems for both the online pharmacies they prescribe from, and can view patient records from previous contact with the service when considering prescription requests.

We found this service provided caring and responsive services in accordance with the relevant regulations; however, improvements were required in relation to providing safe, effective and well led care.

Our key findings were:

- The service had clear systems to keep people safe and safeguarded from abuse.
- There was an adequate system in place to check the patient's identity.
- There were systems in place to mitigate safety risks, including analysing and learning from significant events and safeguarding.
- There were appropriate recruitment checks in place for all staff.
- Prescribing was monitored to prevent any misuse of the service by patients; however, there was no process in place to quality assure GPs' prescribing decisions.
- There were systems to ensure staff had the information they needed to deliver safe care and treatment to patients.
- The service learned and made improvements when things went wrong. The provider was aware of and complied with the requirements of the Duty of Candour.
- Patients were treated in line with best practice guidance and appropriate medical records were maintained.
- The service had a programme of ongoing quality improvement activity.
- An induction programme was in place for all staff, and GPs registered with the service received specific induction training prior to treating patients. Staff, including GPs who worked remotely, also had access to all policies.
- Details of the patient's registered GP were not routinely collected when the patient registered with the service, and prescriptions were issued without information being shared. Following the inspection the service had conducted risk assessments for each of the medicines they had available in order to identify those where

Summary of findings

they considered the risk was such that they could only prescribe safely if the patient's registered GP was notified; however, this assessment did not go far enough in identify medicines which carried significant risk.
- Patient feedback we viewed was generally positive about the quality of the service they received, and we saw evidence that any negative feedback received was followed up, and where necessary, used to improve the service.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints.
- There was a clear business strategy and plans in place.
- Staff we spoke with were aware of the organisational ethos and philosophy and told us they felt well supported and that they could raise any concerns.
- There were clinical governance systems and processes in place to ensure the quality of service provision.
- The service encouraged and acted on feedback from both patients and staff.
- Systems were in place to protect personal information about patients. The service was registered with the Information Commissioner's Office.

We identified regulations that were not being met and the provider must:

- Introduce quality assurance processes to ensure that medicines are prescribed in line with national guidance and internal policy.
- Ensure that there is an effective system in place for the management of patient safety and medicine alerts, which includes a clear audit trail.

The areas where the provider should make improvements are:

- The provider should re-assess the risks associated with the medicines they have available to ensure that they are prescribing these safely.
- The provider should put processes in place to flag when staff training and registrations were due for renewal.
- The provider should consider providing opportunities for GPs to meet as a team (either in person or virtually).
- The provider should review their staffing procedures to formalise the expectation that GPs include their role with the service as part of their NHS appraisal.
- The provider should consider the risks associated with patients being able to revise the answers given in the prescribing questionnaire.

You can see full details of the regulations not being met at the end of this report.

Summary of any enforcement action

We are now taking further action in relation to this provider and will report on this when it is completed.

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 in some areas this service was not providing safe care in accordance with the relevant regulations.

- There were no formal processes in place to routinely monitor prescribing decisions.
- Patient identity was checked by the associated pharmacies when an order was placed; this involved using identity checking software which used the personal details provided by the patient to perform checks against various national databases containing personal information.
- All staff had received safeguarding training appropriate for their role. All staff had access to local authority information if safeguarding referrals were necessary.
- There were enough GPs to meet the demand of the service and appropriate recruitment checks for all staff were in place.
- There were systems in place to meet health and safety legislation and to respond to patient risk.
- There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. 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 not providing effective care in accordance with the relevant regulations.

- We saw evidence that overall, GPs assessed patients' needs and delivered care in line with relevant and current evidence based guidance and standards, for example, National Institute for Health and Care Excellence (NICE) evidence based practice; however, we found some examples of GPs prescribing medicines outside of recommended guidance and the service's own prescribing policy.
- We reviewed a sample of anonymised consultation records that demonstrated appropriate record keeping.
- The service had arrangements in place to coordinate care and share information. Following the inspection, they had undertaken a risk assessment of the medicines they prescribed in order to determine which should only be prescribed in cases where the patient consents to their registered GP being notified; however, a broader consideration of the risks associated with other medicines that they prescribed was needed in order for the risks to patients to be adequately managed.
- The service had a programme of ongoing quality improvement activity. For example, significant events and feedback from staff were used to inform their programme of clinical audit.
- 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.
- The service's website contained information to help support patients lead healthier lives, and information on healthy living was provided in consultations as appropriate.

Are services caring?

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

- GPs told us that they undertook consultations in a private room, for example in their own home.
- We did not speak to patients directly on the day of the inspection; however, we received feedback directly from patients, which we reviewed. The service provided patients with an opportunity to provide feedback once each

prescribing decision was made, and we also reviewed this feedback. Patients expressed satisfaction that their prescription request had been fully considered. We saw evidence that when negative feedback was received, the service contacted the patient to resolve their concern, and that improvements were made to the service following patient feedback.

Are services responsive to people's needs?

We found that this service was providing responsive care in accordance with the relevant regulations.

- There was information available to patients to demonstrate how the service operated.
- Patients accessed the service via the websites of the two associated pharmacies (Assured Pharmacy or Men's Pharmacy). From these websites, patients could select the condition they were seeking treatment for and then select one of the treatments available. Patients then answered a series of questions relating to their condition and general health. If the patient provided answers which indicated that they were suitable to be prescribed the treatment selected, they would then proceed to pay for the treatment.
- Patients could place an order for a medicine at any time, and the service aimed to review prescription requests within one working day.
- Patients could access a brief description of the GPs available on the provider's website.
- There was a complaints policy which provided staff with information about handling formal and informal complaints from patients.
- Consent to care and treatment was sought in line with the provider's policy. All of the GPs had received training about the Mental Capacity Act.

Are services well-led?

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

- There were business plans and an overarching governance framework to support clinical governance and risk management; however, some elements of risk management required further development.
- There was a management structure in place and the staff we spoke with understood their responsibilities. Staff were aware of the organisational ethos and philosophy and they told us they felt well supported and could raise any concerns with the provider or the manager.
- The service encouraged patient feedback. There was evidence that staff could also feedback about the quality of the operating system and any change requests were discussed.
- Systems were in place to ensure that all patient information was stored securely and kept confidential. 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 was a quality improvement strategy and plan in place to make changes in areas identified as needing improvement, such as through clinical audit.

MSF Medical Services Limited

Detailed findings

Background to this inspection

MSF Medical Services provides prescribing services to two online pharmacies (Assured Pharmacy and Men's Pharmacy. The service is run by a GP (who is the registered manager) who provides the prescribing service along with two additional GPs who are contracted by MSF and work remotely. GPs from MSF have access to the online systems for both of the online pharmacies they prescribe from, and can view patient records when considering prescription requests.

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 pharmacist specialist advisor and GP specialist advisor.

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
- Reviewed anonymised patient records

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?

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

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

Keeping people safe and safeguarded from abuse

Staff employed by the service had received training in safeguarding and whistleblowing and knew the signs of abuse and who to report them to. All the GPs had received level three child safeguarding training and adult safeguarding training. It was a requirement for the GPs registering with the service to provide safeguarding training certification. All staff had access to safeguarding policies and could access information about who to report a safeguarding concern to.

The service did not treat children.

Monitoring health & safety and responding to risks

The service held a comprehensive joint risk register with the associated pharmacies, which outlined risks relating to both the prescribing service and the pharmacy, and this was regularly reviewed.

The lead GP worked from a home office; the two contracted GPs also worked from their own homes. The IT system was housed off-site and patients were not treated on the premises.

The provider expected that all GPs would conduct consultations in private and maintain the patient's confidentiality. Each GP used their laptop to log into the operating system, which was a secure programme.

The service was not intended for use by patients with either long-term conditions or as an emergency service.

Staffing and Recruitment

There were enough GPs to meet the demands for the service and there was a rota for the GPs. The associated pharmacies provided a support team, including IT support, to the GPs.

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 GP candidates had to be registered with the General Medical Council (GMC). All GPs were on the GMC GP register with a register to practice and had their appraisal. Those GP candidates that met the specifications of the service then had to provide documents including their medical indemnity insurance, proof of registration with the GMC (or other professional body), proof of their qualifications and certificates for training in safeguarding and the Mental Capacity Act.

We reviewed three recruitment files which showed the necessary documentation was available. The GPs could not begin work with the service until these checks and induction training had been completed. The provider kept records for all staff. At the time of the inspection there was no system in place that flagged up when documentation, such as professional registration, was due for renewal; however, we were told that these were checked during six-monthly appraisal meetings with GPs.

Prescribing safety

All medicines available to be prescribed to patients were monitored by the provider and the associated pharmacies, to ensure prescribing guidance was evidence based; however, there were no arrangements in place for GPs' prescribing decisions to be checked and we found examples of GPs prescribing outside of internal and national guidance. The service had conducted a detailed risk assessment, in conjunction with the two associated pharmacies, to satisfy themselves that the medicines they offered patients were low-risk. For example; they had made the decision not to supply pain relief medicine due to the risks associated with this. The GPs could only prescribe from a set list of medicines to treat specific conditions, such as erectile dysfunction, hair loss, weight loss and period delay. There were no controlled drugs or medicines being prescribed for off licence indicators on this list.

The service's website advertised the medicines that were available, and there was a system in place to prevent the misuse of these medicines. These included the use of patient questionnaires to gather information about a patient's condition and general health to ensure that the medicine was suitable for them, restrictions on the quanities of medicines which could be prescribed to patients, providing information to patients about the appropriate use of the medicine, and contacting patients following the dispensing of their medicines to check whether the treatment provided had been effective. For example, in the case of the prescribing of Orlistat (a medicine to aid weight loss), patients were asked to provide details of their height and weight and about any medical condtions that they had, so that the GP could

determine whether this was an appropriate medicine for them (however, there was no way of objectively measuring or verifying a patient's weight). When the medicine was dispatched to the patient, it was accompanied with an information leaflet about how the medicine should be taken and with information about healthy eating. If the patient requested a further supply of this medicine, a prescription would only be issued if they had lost 5% of their previous body weight from taking the initial course of medicine (in line with National Institute for Health and Care Excellence guidelines). Following the inspection, the service had introduced a further safety system for the prescribing of Orlistat by deciding that they would only prescribe this medicine in cases where the patient had consented to their registered GP being notified.

The service did not issue repeat prescriptions for medicines used to treat patients wth long term conditions.

There were protocols in place for identifying the patient. These involved using identity checking software which used the personal details provided by the patient to perform checks against various national databases containing personal information. We were told that additional identity checks, such as asking the patient to submit a photograph of their passport or driving licence, would be carried out in circumstances where the identity checking software had identified an issue.

Prescription requests were sent through to the service's GPs from the two associated pharmacies. If a prescription was issued, it would be sent back to the relevant pharmacy and the medicine would be dispatched to the patient's specified delivery address via Royal Mail using a service which required the signature of the recipient.

Information to deliver safe care and treatment

For each purchase, patients were subject to identity checks via their payment card. GPs had access to the patient's previous records held by the service.

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; this was done in conjunction with the associated pharmacies, and in cases where the incident spanned both organisations, joint reviews were conducted. Records of safety incidents were kept in a joint "drop box" folder and were available to both staff of MSF and the associated pharmacies.

We reviewed safety incidents and found that these had been fully investigated, discussed, and that as a result, action had been taken in the form of a change in processes. For example, we viewed an incident where the pharmacy had taken an order by phone for a medicine, which had been passed through to a GP for approval despite the patient confirming that they had a condition which made them ineligible to be prescribed this medicine. The reviewing GP had then authorised a prescription for this medicine, believing that the pharmacy would only send through prescription requests for eligible patients. On realising, the GP was able to retrieve the prescription before the medicine had been dispatched to the patient. This incident was discussed amongst GPs and pharmacy staff and a revised protocol for handling requests for this medicine was developed. The patient was also contacted and given an apology and explanation for the reasons for the prescription request being declined.

GPs told us that incidents requiring immediate attention were shared with them at the hand-over at the beginning of their shift and via a communications sheet, which was updated weekly. The Lead GP also met with the two contracted GPs individually on a monthly basis where incidents and issues were discussed; however, at the time of the inspection there was little opportunity for all three GPs to meet as a team.

There were systems in place to deal with medicine safety alerts; however, these did not provide a comprehensive audit trail. Medicines alerts were received by both the Lead GP and the members of the pharmacy team. These were reviewed by the GP on duty, who would take action where necessary on relevant alerts. Copies of alerts which had been reviewed and considered not relevant to the service were saved; however, there was no record of these having been considered.

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.

Assessment and treatment

We reviewed 30 examples of medical records that demonstrated that in most cases, each GP assessed patients' needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) evidence based practice. However, we found examples of prescriptions being issued outside of the service's own prescribing guidelines and NICE standards. For example, a patient had been issed with a prescription for Orlistat (a weight loss medicine) on two occasions despite their weight not having reduced. We also noted examples of patients being issued prescriptions for large quantities of medicines as an initial prescription. For example, a patient was issued with an initial prescription for Sildenafil (a medicine to treat erectile dysfunction) of 64 tablets despite not knowing whether the medicine would be effective for him.

There were no set targets for the number of prescription requests GPs were expected to review, and GPs were not limited in the contact that they could have with patients prior to issuing a prescription.

Patients completed an online form that was specific to the medicine they were requesting. This form included questions about their relevant past medical history. We reviewed 30 medical records which were complete records and adequate notes were recorded. The GPs had access to all previous notes.

In order to request a medicine, patients completed a questionnaire relating to their general health and medical history. If a question was answered in a way that meant they were unsuitable for the medicine requested, they would be stopped from proceeding with the process. For example, patients wishing to purchase weight loss medicines were required to enter their height and weight in order to establish whether their body mass index (BMI) was within a range where the medicine could be effective. If the details entered by the patient showed that their BMI was too low or too high for them to qualify, they were unable to progress with the form. However; patients could change the information entered into the form an unlimited number of times, and the prescribing GP was not alerted to a form having been amended when it was submitted to them.

The GPs providing the service were aware of both the strengths (speed, convenience, choice of time) and the limitations (inability to perform physical examination) of working remotely from patients. They worked carefully to maximise the benefits and minimise the risks for patients. If the provider could not deal with the patient's request, this was adequately explained to the patient and a record kept of the decision.

At the time of the inspection there were no formal arrangements in place for the service to monitor and review prescribing decisions made by their GPs.

Quality improvement

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

- The service used information about patients' outcomes to make improvements; for example, all patients who were prescribed a medicine for the first time were sent an email by the online pharmacy they had used to access the service, asking whether the medicine they had received had been effective and inviting them to provide feedback. Any feedback received which related to the prescription was passed to the GPs in order to determine the effectiveness of the treatment and to provide further advice to the patient if necessary.
- The service took part in quality improvement activity; for example, following a significant event where a patient with dementia had requested medicine via one of the associated pharmacies, the prescribing service, along with the pharmacies, had reviewed the way that they provided care to patients aged 80 years and older and as a result they began providing additional information to patients in this age category to highlight any specific risks posed by taking certain medicines. Following this, an audit was conducted to review the notes of a sample of patients aged 80 years and older to check that the additional information was being provided to them. The audit found that of the 16 records checked, 14 had documented that the additional information had been supplied. The results of the audit had been shared with both GPs and pharmacy staff to highlight the need for this information to be supplied to patients prior to

prescriptions being authorised, in order to give patients the opportunity to submit any additional information about existing health conditions. A re-audit had been scheduled for six months time.

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Staff training

All staff had to complete induction training which consisted of training on using the computer system and an introduction to the staff and processes relating to the associated online pharmacies. All of the GPs working for the service also held roles within the NHS where they were required to undertake training on topics such as the Mental Capacity Act and Safeguarding. We saw evidence that checks were undertaken when these GPs began working for the service to ensure that they were up to date with this training, and we were told that this was reviewed as part of the GPs' six-montly appraisals; however, the service did not have processes in place to flag when registrations expired or re-training was due.

All the GPs had to have received their own appraisals before being considered eligible at recruitment stage. Appraisals of the contracted GPs were carried out by the lead GP; however, notes of these discussions were not detailed and did not include a development plan. We were told that GPs were expected to include information about their work with the service as part of their external GP appraisal; however, we could see no evidence of this expectation being formalised.

Coordinating patient care and information sharing

When a patient requested a prescription via one of the associated online pharmacies, they were asked whether they would like the service to contact their registered GP on their behalf to share details of the prescription issued. If patients consented to this contact being made, they were asked to provide details of their registered GP. The service did not collect details of patients' registered GPs at the point of registration with the service, and it was not mandatory for patients to provide these details. Following the inspection the service had carried-out a risk assessment of the medicines they supplied in order to identify potential risks to patients and put arrangements in place to mitigate these risks. The sevice had identified one medicine (Orlistat, a medicine to aid weight loss) which they had decided should only be prescribed in cases where they could share information about the prescription with the patient's registered GP. However, a broader consideration of the risks associated with other medicines that they prescribed was needed in order for the risks to patients to be adequately managed; particularly concerning the risks relating to the prescribing of medicines to treat impotence.

Supporting patients to live healthier lives

The service identified patients who may be in need of extra support and a range of information was available via the websites of the two associated pharmacies. Additional information was also provided to patients via email when their prescription request was agreed, and this was enclosed with their medicines when they were dispatched. For example, patients requesting weight loss medicines were provided with information on healthy eating.

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

We were told that the GPs undertook consultations in a private room and were not to be disturbed at any time during their working time. At the time of the inspection there were no quality assurance arrangements in place to ensure that GPs were complying with the expected service standards and communicating appropriately with patients.

We did not speak to patients directly on the day of the inspection. However, we reviewed feedback that patients had submitted to us prior to the inspection. Ten patients provided feedback and all were happy with the service provided. Patients were sent an email asking for feedback on the prescribing service following each prescribing decision being made. We reviewed a summary of this feedback from the period January to March 2017 which showed that of 209 patients who completed the survey 207 gave positive feedback. Patients were also sent a follow-up email by the pharmacy shortly after their medicines had been dispatched, asking for feedback about the effectiveness of the treatment. They could also rate the overall service via Trustpilot.

Involvement in decisions about care and treatment

Patient information guides about each of the medicines available was provided on the webisites of the two online pharmacies, and additional information about each medicine was also included when the medicine was dispatched. There was a dedicated team of pharmacy assistants to respond to any enquiries about medicines (under the supervision of a qualified pharmacist). Assistance with technical queries was also available to patients.

Patients had access to information about the GPs available; however, they could not choose which GP considered their prescription request.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting patients' needs

Patients accessed the service via the websites of either Assured Pharmacy or Men's Pharmacy. From these websites patients could select the condition they were seeking treatment for and then select one of the treatments available. Patients then answered a series of questions relating to their condition and general health. If the patient provided answers which indicated that they were suitable to be prescribed the treatment selected, they would then proceed to pay for the treatment. The treatment request would then be accessed by a GP from MSF Medical Services, who would assess the information provided by the patient, in conjunction with details of previous treatment from the pharmacy, and make a decision about whether to issue a prescription. In some cases, the GP would contact the patient to gather additional information before issuing a prescription. If a prescription was issued, this would be sent through to the pharmacy, who would dispatch the medicine. If the GP decided that the treatment was not suitable for the patient, they would send them an email explaining the reasons for their decision and payment would be refunded.

The digital application allowed people to contact the service from abroad but all medical practitioners were required to be based within the United Kingdom.The medicines for any prescriptions issued were delivered within the UK to the patient's selected address.

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

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.

Managing complaints

Information about how to make a complaint was available on the service's website. The provider had developed a complaints policy and procedure. The policy contained appropriate timescales for dealing with the complaint. There was escalation guidance within the policy; however, this guided patients to complain to the General Medical Council if they were unhappy with the provider's response to their complaint, which may not always be appropriate.

Complaints relating to the prescribing service were usually received via the pharmacy that the patient had used to access the service. Any complaints which related specifically to the prescribing service would be sent to the Lead GP by the pharmacy, and the GP would respond directly to the patient. Details of all complaints relating to both the prescribing service and the pharmacies were jointly recorded and were reviewed annually in joint meetings in order to identify trends and discuss improvements to the system. The outcomes of these meetings were shared with the contracted GPs.

There had been a total of two complaints made specifically about the prescribing service in the past 12 months. We reviewed both of these and found that they were satisfactorily handled. For example, one patient complained that their request for a medicine had been declined. The response from the service explained that a prescription could not be issued due to the patient having a pre-existing condition which heightened the risk of taking the medicine requested. The response advised the patient to visit their registered GP, who may be able to prescribe the medicine, as they would be in a position to closely monitor the patient.

Consent to care and treatment

There was clear information on the service's website with regards to how the service worked and what costs applied. The website had a set of terms and conditions and details on how the patient could contact them with any enquiries. Patients paid the advertised fee for the medicine they requested; there was no additional fee for their prescription or for the processing or shipping of their order.

All GPs 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.

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 in one area this service was not providing well-led care in accordance with the relevant regulations.

Business Strategy and Governance arrangements

The provider told us they had a clear vision to work together with the two associated pharmacies to provide a high quality responsive service that put caring and patient safety at its heart. We reviewed the provider's high-level business plan, which set out objectives relating to the growing of the business (in association with the two online pharmacies), and fulfilling a role in health promotion, specifically aimed at medical problems experienced by men.

There was a clear organisational structure and staff were aware of their own roles and responsibilities. There was a range of service specific policies which were available to all staff.

There was no formal process in place for checks to be made to monitor the quality and performance of the service. The Lead GP held regular meetings individually with the two contracted GPs and with staff from the associated pharmacies, during which significant events, complaints, and quality improvement were discussed; however, the service lacked the mechanisms to ensure that a comprehensive understanding of the performance of the service was maintained, for example, there was no process of quality assurance to monitor whether prescribing decisions were appropriate.

There arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, in relation to prescribing safety, the provider's assessment of risk was not sufficiently broad to effectively mitigate risks to patients.

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

Leadership, values and culture

The founding director was responsible for the business and worked in conjunction with the senior management teams for the two pharmacies. There were three GPs working part time for the service, who undertook all the prescribing for the pharmacies and ensured that between them a prescribing facility was available Monday to Friday.

The values of the service were: "To provide safe, effective, reliable, discreet, accurate and up to date, caring and patient-centred prescribing services working in partnership with our healthcare partners, Assured Pharmacy and GPT Medical Services Ltd (trading as "Men's Pharmacy")."

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

Safety and Security of Patient Information

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

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

Seeking and acting on feedback from patients and staff

Patients could provide feedback and rate the service they received. Once a decision was made on whether to authorise a prescription request, an email was sent to the patient, explaining the decision and inviting them to provide feedback on the prescribing service. This feedback was reviewed by GPs daily to monitor for any comments which required a response, and was also collated to give an overview of patient satisfaction with the service. Patients were also able to provide a rating on the whole experience of the pharmacy and prescribing service via Trustpilot. A link to the Trustpilot feedback was available on the websites of the two pharmacies.

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

The provider had a whistleblowing policy in place. A whistleblower is someone who can raise concerns about practice or staff within the organisation. The founding director was the named person for dealing with any issues raised under whistleblowing.

Are services well-led?

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

Continuous Improvement

The service consistently sought ways to improve. All staff were involved in discussions about how to run and develop the service, and were encouraged to identify opportunities to improve the service delivered.

The contracted GPs told us that the monthly meetings with the Lead GP were the place where they could raise concerns and discuss areas of improvement; in addition, the GP team worked closely together and frequently communicated via telephone and email.

There was a quality improvement strategy and plan in place to make changes in areas identified as needing improvement, such as through clinical audit. For example, one of the service's GPs noted that a number of patients were using a medicine to treat erectile dysfunction on a daily basis; this was discussed in a meeting with the pharmacy director and a review was undertaken to establish whether any clinical studies had been undertaken about the long-term effects of using this medicine daily. Research undertaken by the pharmacy team highlighted that the medicine was considered safe to take daily but that no studies had been performed over a period longer than 12 months. Having reviewed this information, it was decided that all patients who were taking this medicine daily would be contacted by email at the time of their next order to explain that no long-term studies had been done on the daily use of the medicine, and inviting the patient to contact the service to discuss any concerns that they had.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had failed to ensure that in all cases, medicines were prescribed in line with national guidance and internal policy. There were no quality assurance processes in relation to prescribing decisions. The provider had not ensured that there was an effective system in place to provide an audit trail for decisions about the relevance of patient safety and medicine alerts. This was a breach of Regulation 12 (1) of the Health and Social Care Act 2008.