Freedomhealth Ltd

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Inspection report

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Date of inspection visit: 3 May 2017
Date of publication: 13/07/2017

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Freedom Health Limited on 3 May 2017. Freedom Health Limited offers a digital service that allows patients to obtain a prescription and obtain medicines from an affiliated pharmacy. Freedom Health Limited also provides private general practice, specialist sexual health services and cosmetic treatments, however, this inspection focused on the digital service.

We found this service did not provide safe, effective, responsive and well led services in accordance with the relevant regulations. However, they were providing a caring service.

Our key findings were:

- There were no systems in place to protect patient information and ensure records were stored securely.
- On registering with the service, patient identity checks were limited; other than via a credit/debit card check. The provider could not be sure they were consulting with the person who owned the card.
- There were enough GPs to meet the demand of the service and appropriate recruitment checks for all staff were in place.
- We found that assessments of patient needs and care were not being delivered in line with relevant and current evidence based national guidance and standards.
- The service did not have arrangements in place to coordinate care and share information appropriately for example, when patients were referred to other services.
- There was a complaints policy which provided staff with information about handling formal and informal complaints from patients. Verbal complaints had not been recorded or used to analyse trends and to inform learning.
- The provider told us they had a clear vision to provide an accessible and responsive service. However, our inspection found that systems and processes to govern activity were not always effective.
- There was no business continuity plan to consider how the service would continue if there were any adverse events, such as IT failure or building damage.
- Practice policies were available but not all were followed.
- The provider engaged fully with the inspection process and was keen to implement changes to mitigate the risks highlighted.

We identified regulations that were not being met. The areas where the provider must make improvements are:

- Ensure there are robust governance arrangements in place to identify, assess and monitor risks and the quality of the service.
- Ensure that identity of a patient is confirmed.
- Ensure that information provided by the patient is fully assessed.

Summary of findings

- Ensure that care and treatment is delivered in accordance of evidence based guidelines.
- Ensure that practice policies are in place and followed by staff.
- Ensure there is a programme in place of quality improvement.
- Ensure that patient records are complete and accurate and information is shared with a patient's GP in accordance with General Medical Council (GMC) guidance.
- Ensure all complaints are logged and responded to in accordance with the provider policy.

The areas where the provider should make improvements are:

- Consider documenting team meetings to ensure improved record keeping and evidence learning significant events.

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.

Following our inspection of the service we imposed a condition on the provider's registration to prevent the provider from providing any Digital and Online Services to patients which fall within the scope of the regulated activity: Treatment of disease, disorder or injury.

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 no systems in place to protect patient information and ensure records were stored securely.
- On registering with the service, patient identity checks were limited; other than via a credit/debit card check. The provider could not be sure they were consulting with the person who owned the card.
- The service was not intended for use as an emergency service. The system was not designed to manage any emerging medical issues during a consultation but the system would highlight any clinical concerns to the GP reviewing the form.
- The service did not have a business contingency plan. Prescribing and consultations were not monitored for any risks.
- Disclosure and Barring Service (DBS) checks were not undertaken every three years as detailed in the provider policy. (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).
- There were systems in place for identifying and investigating incidents relating to the safety of patients and staff members. However, there was no evidence of any learning shared with all staff members or changes implemented to improve patient safety.
- The provider encouraged 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.
- Some staff had not received safeguarding training appropriate for their role; however this was rectified the day after the inspection. All staff had access to local authority information for adults if safeguarding referrals were necessary. However, no contact details were available regarding safeguarding children.
- There were systems in place to meet health and safety legislation but not to respond to patient safety risk.

Are services effective?

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

- On registering with the service, patient identity checks were limited; other than via a credit/debit card check. The provider could not be sure they were consulting with the person who owned the card.
- 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.
- The service did not have any policies in place to assist in assessing capacity and consent for the digital service and there was no means of highlighting vulnerable people on the system. The staff told us they could only assess mental capacity based on the information provided on the consultation forms.
- We found that assessments of patient needs and care was not being delivered in line with relevant and current evidence based guidance and standards, for example, National Institute for Health and Care Excellence (NICE) evidence based practice. We reviewed a sample of anonymised consultation records that demonstrated a lack of appropriate record keeping and patient treatment.
- Record keeping was inconsistent and not all patient information gathered was attached to the patient record.
- The service did not have arrangements in place to coordinate care and share information appropriately for example, with a patient's regular GP when necessary.

Summary of findings

- If the provider could not deal with the patient's request, this was adequately explained to the patient; however, a record of the decision was not kept.
- The service's website contained information to help support patients lead healthier lives, and information on healthy living was provided in consultations as appropriate.
- 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.

Are services caring?

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

- Systems were not in place to ensure all patient information was stored securely and kept confidential.
- We did not speak to patients directly during our inspection. We looked at patient reviews of the service which showed that 95% of patients were satisfied with the level of service they received.
- Patients could only access consultation forms in English. The provider told us that they were upgrading the system to enable other languages to be used.

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 the service by phone or e-mail. The provider's website was available 24 hours a day and the service operated between 9am and 5pm, Monday to Friday.
- The service gathered feedback from patients through an online review website.
- There was a complaints policy which provided staff with information about handling formal and informal complaints from patients. Verbal complaints had not been recorded or used to analyse trends and to inform learning.

Are services well-led?

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

- The provider told us they had a clear vision to provide an accessible and responsive service. However, our inspection found that systems and processes to govern activity were not effective.
- Patient identity checks were limited; other than via a credit/debit card check.
- Disclosure and Barring Service (DBS) checks were not undertaken every three years as detailed in the provider policy. (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).
- Record keeping was inconsistent and not all patient information gathered was attached to the patient record.
- The provider encouraged a culture of openness and honesty.
- Practice policies were available but not all were followed.
- There was no formal system in place for quality improvement, including clinical audits, of the service.
- Staff told us that clinical meetings were happening but they were not minuted.
- There was no business continuity plan to consider how the service would continue if there were any adverse events, such as IT failure or building damage.
- There was a management structure in place and the staff we spoke with understood their responsibilities.

Freedomhealth Limited

Detailed findings

Background to this inspection

Freedom Health Limited offers a digital service providing patients with prescriptions for medicines that they can obtain from the affiliated registered pharmacy. We inspected the digital service at the following address: 60 Harley Street, London, W1G 7HA, which was located within an independent GP practice. The GPs' working for the digital service also worked in the practice.

Freedom Health Limited was originally established in 1997, and has evolved to provide an online service (since 2011) that allows patients to request prescriptions through a website (this is the service we inspected). Patients are able to register with the website, select a condition they would like treatment for and complete a consultation form which is then reviewed by a GP and a prescription is issued if appropriate. Once the consultation form has been reviewed and approved, a private prescription for the appropriate medicine is issued. This is sent to the affiliated pharmacy before being dispensed, packed and sent to the patient by secure post (The pharmacy is regulated by General Pharmaceutical Council).

The service can be accessed through their website, www.freedomhealthonline.co.uk where patients can place orders for medicines seven days a week. The service is available for patients in the UK only aged over 18 years. Patients can access the service by phone or e-mail from 9am to 5pm, Monday to Friday. This is not an emergency service. Subscribers to the service pay for their medicines when making their on-line application.

Over the last 12 months the service has undertaken digital consultations for over 10,000 patients.

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

How we inspected this service

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

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 a sample of patient records as we had identified concerns with the level of care.

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

Safety and Security of Patient Information

Systems were not in place to ensure that all patient information was stored and kept confidential. There were no policies in place, for the IT systems, to protect the storage and use of all patient information and to instruct staff working off site how to access patient information safely. The service could not provide a clear audit trail of who had access to records. We were told by the registered manager that although they had a password to protect their computer this was stored on the computer which increased the risk of unauthorised accessing of information. The remote GP had a password to protect patient information.

The service and GPs' were registered with the Information Commissioner's Office.

The provider made it clear to patients what the limitations of the service were. There was a system in place for managing test results and referrals. The service was not intended for use as an emergency service. The system was not designed to manage any emerging medical issues during a consultation but the system would highlight any clinical concerns to the GP reviewing the form.

The service was prescribing medicines for use by patients with long term conditions, without ensuring appropriate monitoring or sharing of information relating to their care with the patient's GP, in line with General Medical Council (GMC) guidance.

On registering with the service, patient identity checks were limited; other than via a credit/debit card check. The provider could not be sure they were consulting with the person who owned the card.

The GPs had access to the patient's previous orders held by the service. The full history of the patient was not visible to all GP's. Email correspondence was only visible to the GP who sent it. Also, we saw verbal conversations with patients were not recorded in the patient records. The provider told us that they were in the process of transferring to a new patient record system which would enable them to improve their record keeping. At the time of inspection the new system was not in use.

The provider had a policy not to provide care or treatment to persons under the age of 18 years; however, there were no safeguards in place to ensure that patients were over 18 years of age.

Prescribing safety

Medicines prescribed to patients during a digital consultation were not 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 GPs could only prescribe from a set list of medicines, for example; contraceptive tablets, statins for high cholesterol, inhalers for asthma, chlamydia and genital herpes treatment. There were no controlled drugs on this list.

We asked how the provider ensured that they followed current prescribing guidelines. The consultation forms had been developed by the medical director working with a pharmacist from one of the supplying pharmacies. However, there was no formal review programme in place to ensure they followed best practice guidelines.

The consultation forms asked a range of questions about symptoms experienced. There was also a range of frequently asked questions on the website for each medicine. However, the forms we viewed did not support the ability for practitioners to conform with NICE guidance and General Medical Council (GMC) prescribing guidelines. For example, for patients requesting asthma treatments the consultation form did not include the completion of the Asthma Control Test or the three questions commonly used to assess the patients current asthma control, as recommended by the Royal College of Physicians. The service did not routinely communicate with the patient's regular GP to ensure their asthma was being appropriately managed. We found that the provider prescribed numerous asthma medicines, on repeated occasions without any further communication with the patient's GP. There was no documented evidence of the rationale for this in the patient's notes.

The provider issued reliever inhaler prescriptions for asthma, based on information supplied by the patient to show that they had previously been prescribed the medicine. Up to two inhalers could be ordered in one transaction. We saw for one patient that they had requested two inhalers per month for a period of 11 months. For this patient there was only one record to show

that the request had been questioned on the eleventh occasion. There was no evidence that there had been any communication with the patient's usual GP about the numbers of these inhalers supplied. Using reliever inhalers regularly can be a sign of poorly controlled asthma, which increases the risk of an asthma attack, the outcome of which could be a serious risk to life. We were told by the medical director that they have not clarified a patient's history with their GP in the last 12 months and that for the majority of patents they did not have GP details.

The provider agreed on the day of our inspection that prescribing inhalers without informing a patient's GP increased patient risk and made it more difficult for a GP to support their asthmatic patients safely.

Once the GP selected the medicine and correct dosage of choice, relevant instructions were given 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.

The provider prescribed antibiotics for a small range of conditions. There were strict timeframes in place for the issuing of repeat prescriptions.

The service had previously prescribed some medicines for unlicensed indications, for example for jet lag and altitude sickness.Medicines are given licences after trials which show they are safe and effective for treating a particular condition. Use for a different medical condition is called 'unlicensed use' and is a higher risk because less information is available about the benefits and potential risks. There was clear information on the website to explain that the medicines were being used 'in an unlicensed manner, and the patient had to acknowledge that they understood the information on the website. Additional information, to guide the patient when and how to take these medicines was available on the webpage. However, we did not see evidence of consent by the patient to acknowledge and accept that they were receiving a medicine for use outside of its licence and that they understood the full implications of this. We also found that there was no contemporaneous recording of the decision to prescribe. Emails to and from patients confirming their travel itinerary were not stored alongside the patient's medical record to ensure that all GPs' had access to this information to enable them to prescribe the appropriate medicines for the intended destination and length of stay.

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. However, there was no evidence to demonstrate that incidents or significant events were analysed for trends, and that learning was shared with staff.

The provider told us they held clinical meetings regularly where incidents and complaints were communicated and discussed with all staff. However, there were no meetings minutes to demonstrate that these had been discussed and that any implemented changes had been communicated with all staff. The clinical staff told us that these discussions took place but minutes of the discussions were not taken.

We asked how patient safety alerts were dealt with such as those issued by the Medicines and Healthcare products Regulatory Agency (MHRA), and were told and saw that these were reviewed by the medical director and prescribers.

Safeguarding

Arrangements for safeguarding did not reflect relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. However, the lack of identity checking did not ensure patients would be safeguarded from abuse or harm. The provider told us they accepted there was a risk of patients being exploited but that they trusted the information that patients supplied on the consultation forms was correct without questioning it.

Staff told us that although patient's GP contact details were requested via the online consultation forms this information was not required to enable patients to order medicines and this could be problematic if there were any safeguarding concerns and contact with the GP was required.

Not all clinical staff employed at the headquarters had received update training in safeguarding adults and children. However, this was rectified the day following the inspection. There was a policy in place which advised staff

about the signs of abuse. There was information on who to contact within the local authority for safeguarding adults, however, the policy did not provide the same details for children.

Staffing and Recruitment

At the time of our inspection, there were enough staff, including GPs', to meet the demands for the service. There were two GPs' and two administration team members to deal with the digital service.

We reviewed four recruitment files which showed the necessary documentation was available. The GPs 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 GPs. However, there was no system in place that flagged up when any documentation was due for renewal such as their professional registration.

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 working in the NHS and continue to do so and be registered with the General Medical Council (GMC). All candidates were on the GMC register 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, proof of their qualifications and certificates for training in safeguarding and the Mental Capacity Act and Disclosure and Barring Service (DBS) checks.

The provider had a policy for 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). The policy detailed that DBS checks would be undertaken every three years for all staff. However, we found that for all four members of staff the last check was over three years ago.

Monitoring health & safety and responding to risks

As the GPs' were unable to see each other's electronic correspondence with patients and verbal communication was not recorded there was no system for them to carry out checks on approved consultations and prescriptions to ensure they were appropriate.

The provider headquarters was located within an independent GP practice. Patients for the GP practice were treated on the premises. GPs carried out the online consultations either within the practice or remotely; usually from their homes. Staff had received in house induction 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 policy detailing the requirements for data protection. Each GP used their laptop to log into the operating system, which was a secure programme. However, we were told that the provider stored their password on the computer which may make it accessible. There was no evidence that remote GPs had completed a home working risk assessment to ensure their working environment was safe.

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 clear information on the service's website with regards to how the service worked and what costs were 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. Information about the cost of the consultation and medicine was known in advance and paid for before the consultation appointment commenced.

All 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. The process for seeking consent was monitored through audits of patient records. The service did not have any policies in place to assist in assessing capacity and consent for the digital service and there was no means of highlighting vulnerable people on the system. The staff told us they could only assess mental capacity based on the information provided on the consultation forms.

Assessment and treatment

We reviewed 34 examples of medical records and found that care was not being delivered in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) guidelines. For example, repeated requests for asthma inhalers were dealt with inappropriately.

Patients completed an online form which included their past medical history, symptoms and any medicines they were currently taking. There was a set template to complete for the consultation that included the reasons for the consultation and the outcome to be manually recorded. Patients would also be responsible for selecting what dose of medicine they required. We reviewed 34 medical records and observed they were not complete records and did not have adequate notes recorded. The GPs did not have access to all previous notes. Record keeping was inconsistent and not all patient information gathered was attached to the patient record.

The GPs providing the service were aware of the strengths (speed, convenience, choice of time) however, the limitations (inability to perform physical examination, lack of access to medical records, inability to ensure the patient is who they say they are) of working remotely from patients had often been overlooked. For example, we were told that patients did not often consent to providing GP details as they wanted their treatment to be confidential. However, the provider had not considered that this could also result in patients being dishonest or at risk of abuse of exploitation.

If the provider could not deal with the patient's request, the provider told us that this was adequately explained to the patient however, there was no evidence of a record kept of the decision.

Management, monitoring and improving outcomes for people

The service did not monitor consultations, or carry out prescribing audits to improve patient outcomes. There was no formal programme in place for clinical audits or quality improvement to assess the service provision.

Prescribing was not audited to identify areas for quality improvement, although we saw that the provider had undertaken a review of the records containing GP contact information. This review showed that the percentage of records containing this information had declined from 1% to less than 0.5% over the previous 12 months.

We asked to see examples of quality improvement activity, for example clinical audits. The prescribers told us that they did not audit their prescribing overall, but clinical meetings took place regularly where prescribing decisions were discussed. There was no evidence to support the provider undertaking a systematic review of prescribing patterns against best practice standards and did not have a process in place for identifying improvements.

We were told that patients had the opportunity to rate the service on an online system called "Trustpilot" which is an open system provided by a third party supplier. Over the last 12 months there had been 22 reviews with 21 of them being positive about the level of service received.

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 registered GP. The provider requested information from the

Are services effective?

(for example, treatment is effective)

patient about their GP when they registered to join the service. Every contact with the patient recommended informing the GP. However the provider had not carried out a risk assessment to identify which medicines would only be prescribed if a patient were to consent to the sharing of information with their own GP. The medical director told us that less than 1% of the records that they had surveyed contained patient GP contact details. This is not in accordance with the GMC best practice guidance in relation to remote prescribing.

Patients who needed further screening or tests were either sent a test kit or referred to their own GP. For example, chlamydia test kits were sent to the patient by post with instructions on how to obtain a sample for testing. The patient would then send the sample in the enclosed pre-paid envelop to a laboratory. The result was then sent back to the provider who shared the information with the patient either via e-mail or over the phone, as requested by the patient.

Supporting patients to live healthier lives

The service identified patients who may be in need of extra support and had a range of information available on the website. For example, the provider had a section on their website for a range of health advice on topics such as smoking cessation, safe sex and diet. Where the provider could not assist a patient, they directed them to the NHS Choices website for services that may be more appropriate for the patient. The provider also had an advice system set up on their webpage that enabled patients to gain advice anonymously for sensitive issues.

Staff training

All staff had to complete an induction which consisted of fire safety, first aid and moving and handling which was offered in house. The GP registered with the service had to receive specific induction training prior to treating patients. An induction log was held in each staff file and signed off when completed. Administration staff received annual performance reviews. The GP had to have received their own appraisals before being considered eligible at recruitment stage and provide evidence of this. There were systems in place to monitor when staff were due to have their appraisal. We saw that the only employed GP had discussed the provision of online consultation at their last appraisal. The provider did not have records of ongoing training for clinical members of staff but this was provided to us following the inspection.

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 not in place to ensure that all patient information was stored and kept confidential.

We were told that the GPs undertook consultations in a private room. The provider did not carry out random spot checks to ensure the GPs were complying with the expected service standards and communicating appropriately with patients.

We did not speak to patients directly as part of the inspection but we did review survey information that was available online which showed that patients responded positively to the service. The latest survey information available showed 95% of patients were satisfied with the level of service received in the last 12 months.

Involvement in decisions about care and treatment

Patient information guides about how to use the service were available. There was a dedicated team to respond to any enquiries and patients had access to information about the GPs available.

Information on the provider's website informed patients about each medicine that was on offer and what might be the suitable dose for the condition it was intended for. Pricing for consultations was also clearly displayed on the website.

Patients had access to information about the GPs available and could book a consultation with a GP of their choice. For example, whether they wanted to see a male or female GP.

The latest survey information available from the previous 12 months responses indicated that 21 out of 22 patients were satisfied with the explanation of their condition.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting patients' needs

The service can be accessed through the provider's website, www.freedomhealth.co.uk and www.freedomhealthonline.co.uk, where patients could place orders for medicines seven days a week. The service was only available for patients over 18 years and living in the UK. Patients could also access the service by phone or e-mail from 9am to 5pm, Monday to Friday. This service was not an emergency service. Patients who had a medical emergency were advised to ask for immediate medical help via 999 or if appropriate to contact their own GP or NHS 111.

Patients selected the treatment or medicines they required, filled in a consultation form and paid for the cost of the medicines and the consultation. The consultation form was then reviewed by a GP, and once approved; a prescription was issued to one of two affiliated pharmacies. Where required the GP would contact patients for further information before approving the consultation form. These contacts were not always recorded in the patient's notes to enable all GPs' to view the complete record.

The digital service did not allow people to use the service from abroad and all medical practitioners were required to be based within the United Kingdom. Any prescriptions issued were delivered within the UK to an address of the patient's choice.

Other than using Trust Pilot the provider had not undertaken any further surveys to gain feedback from patients about their experience when using the service.

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 GPs' available. At the time of our inspection, there were one male and one female GP available.

Staff told us that translation services were not available for patients who did not have English as a first language. The provider's website only had information and application forms in English. The provider told us they had considered translation services and were working on sourcing a reliable and trustworthy translation service.

Managing complaints

Information about how to make a complaint was available on the service'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 has been developed and introduced for use.

We reviewed the complaint system and noted that complaints made to the service had not been recorded. The provider told us the only complaints they had received were verbal and regarding dispatch times. They stated they felt these did not need to be documented if they were dealt with at the time of complaint.

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 services in accordance with the relevant regulations.

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. However, the provider did not have a business plan to include improvements to the service such as improving the way patients were identified, and completing a full review of current clinical guidelines. There was no business continuity plan to consider how the service would continue if there were any adverse events, such as IT failure or building damage. They provider had not ensured arrangements were in place to store patient information for the appropriate timescale should the business cease to operate. The provider told us that they were in the process of transferring to a new data storage provider to enable this to happen.

There was a lack of compliance with the provider's own policies. The previous Disclosure and Barring Service (DBS) check for all staff members was over three years ago. The provider had not followed their own policy, which stated that all staff will have a DBS check every three years. (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).

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

There were no checks in place to monitor the performance of the service, including random spot checks for consultations. We were told that any clinical information was discussed at weekly clinical meetings. However, those meetings were not minuted and therefore, the provider could not demonstrate that learning from issues, complaints and significant events were discussed and shared with staff.

There were no systems in place to assess patient risk. The provider had not considered risks to patients or taken actions to mitigate those risks.

Care and treatment records were not complete, legible and accurate, and systems were not in place to ensure they were securely kept.

Leadership, values and culture

The registered manager had responsibility for any medical issues arising. There were arrangements in place for the second GP to cover absences and leave. The registered manager was on site during the service opening times to support staff should any issues arise.

The service told us they 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. However, we found that when patient data was possibly compromised by an affiliated pharmacy. The provider sourced a different pharmacy service but no attempt was made to inform patients that their information may have been shared inappropriately by the pharmacy. The provider told us they felt that the likelihood of their patients being affected was low, although details of who was affected was not available.

Safety and Security of Patient Information

There were no policies in place, for the IT systems, to protect the storage and use of all patient information and to instruct staff working off site how to access patient information safely. The service could not provide a clear audit trail of who had access to records and from where and when. We were told by the registered manager that although they had a password to protect their computer this was stored on the computer and, therefore, easily accessible by others. There were no business contingency plans in place to minimise the risk of losing patient data. The service was registered with the Information Commissioner's Office.

Seeking and acting on feedback from patients and staff

Patients had the opportunity to rate the service on an online system called "Trustpilot" which was an open system provided by a third party supplier. At the end of every consultation, patients were sent an email asking for

Are services well-led?

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

their feedback. Patient feedback was published on the service's website. Patients could also contact the service directly to ask questions or raise a concern and the contact details was clearly displayed on the website.

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 registered manager was the named person for dealing with any issues raised under whistleblowing.

Continuous Improvement

The service did not seek ways to improve from complaints. 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. Minutes were not available to show improvements were discussed.

There was no quality improvement strategy and plan in place to monitor quality and to make improvements, for example, through clinical audit.