

Index Medical Limited

Index Medical Limited

Inspection report

2 Westbury Mews,
Westbury Hill,
Westbury-on-Trym
Bristol
BS9 3QA

Tel: 0117 9273753

Website: www.doctorfox.co.uk

Date of inspection visit: 4 May 2017

Date of publication: 10/07/2017

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Index Medical Limited on 4 May 2017.

Index Medical Limited provides an online primary care consultation service and medicines ordering service. Patients register for the service on the provider's website.

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

Our key findings were:

- There were clinical governance systems and processes in place to ensure the quality of service provision, however these did not always operate effectively. For example, we found adequate insurance policies were not in place, for example, employer liability insurance, public liability insurance. The provider was also unable to provide confirmation and evidence of adequate medical indemnity insurance for two of the GPs. Post inspection we received evidence that these had been put into place.
- There was not a comprehensive system in place to check patient's identity.
- Patients could access the service by phone or e-mail from 9am to 5pm, Monday to Saturday. The provider's website was available 24 hours a day.
- Systems were in place to protect personal information about patients. Both the company and individual GPs were registered with the Information Commissioner's Office.
- The service gave patients the option to share information with their GP but we found evidence of prescribing that was not consistent with evidence based guidance, for example NICE (National Institute for Clinical Excellence) relating to asthma reliever inhalers. Prescribing was monitored to prevent any misuse of the service by patients and to ensure GPs were prescribing appropriately.
- There were systems in place to mitigate safety risks including analysing and learning from significant events and safeguarding.
- The provider was aware of and complied with the requirements of the Duty of Candour.
- There were appropriate recruitment checks in place for all staff.
- An induction programme was in place for all staff. However the provider was not able to evidence that this had taken place for all members of staff.
- Patients were treated in line with best practice guidance and appropriate medical records were maintained.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints.

Summary of findings

- Survey information we reviewed showed that over 99% of patients were happy with the service they had received.
- 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.
- The service encouraged and acted on feedback from both patients and staff.

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

- Ensure care and treatment are provided in a safe way for service users.
- Ensure they operate effective systems and processes to assess and monitor the service.

The areas where the provider should make improvements are:

- Ensure systems and processes are reviewed for patients to acknowledge and consent to being prescribed medicines for unlicensed use.
- Ensure systems and processes are reviewed with regards to record keeping of inductions undertaken by new staff.
- Introduce a process to review patients who may have been prescribed medicines which were the subject of medicine alerts.

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

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.

- The provider did not have an effective system in place to check the identity of patients using the service.
- We did not see evidence of consent by the patient to specifically acknowledge and accept the implications that they were receiving a medicine for use outside of its license.
- The processes to ensure patient safety alerts issued by the Medicines and Healthcare products Regulatory Agency (MHRA) was not embedded and did not ensure that these were consistently responded to appropriately.
- Amendments to consultation questionnaires were made by a GP without a license to practice.
- The provider issued reliever inhaler prescriptions for asthma. Patients could be supplied with up to eight inhalers over a 12 month period without informing their GP of the supply. We raised this as an area of concern with the provider who immediately changed the maximum quantity of inhalers that could be supplied to one inhaler and added a requirement that the patient's GP must be informed of every supply.
- The safeguarding policy did not have a named person as the lead. Post inspection we received information that a GP with the appropriate level training had been nominated as the safeguarding lead.
- Disclosure and Barring Service (DBS) checks were not up to date for all members of staff.
- The location where regulated activities were registered to be carried out had no business insurance or public liability insurance. We also found that the provider had no employee liability insurance in place, which is a legal requirement. We told the provider of our concerns and we received, the day following the inspection, confirmation that all forms of insurance were now in place.
- The provider had risk assessed all areas of potential prescribing by the service and taken the decision not to provide medicines for chronic diseases other than asthma.
- We were told that in certain clinical areas, for example, contraceptive supplies and a treatment for acne, medicines would not be supplied without a patient's permission to notify the patient's own GP.
- A detailed policy was in place of what to do in the event of a medical emergency occurring during a consultation.
- The service had a business contingency plan.
- Prescribing was constantly monitored and all consultations were monitored for any risks.
- 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.
- 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.

Are services effective?

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

- Consent to care and treatment was sought in line with the provider policy. All of the GPs had received training about the Mental Capacity Act.
-

Summary of findings

- We were told that each GP 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.
- The service had arrangements in place to coordinate care and share information appropriately for example, when patients were referred to other services.
- 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.
- The service's web site 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. However, the provider did not hold records of the induction that staff had received.

Are services caring?

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

- We were told that GPs undertook consultations in a private room for example in their surgery, at the service or own home.
- We did not speak to patients directly on the days of the inspection. However, we reviewed the latest survey information. An independent survey via Trusted Shops showed that in the previous 12 months approximately 3000 reviews had been received and that 99% of reviewers found the services to be excellent (93%) or good(6%).
- At the end of every consultation, patients were sent an email asking for their feedback. We saw that 94% of patients were extremely happy or happy with the service and that 94% of patients found the health information available on the website as extremely or very useful.
- There was a dedicated team to respond to any enquiries. A survey of 53 patients who had queries about the service showed that 93% of those patients stated that the service was extremely or very effective at responding to their queries.

Are services responsive to people's needs?

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

- Patients could access the names of the available clinicians on the provider's website.
- There was information available to patients to demonstrate how the service operated.
- Patients could access the service by phone or e-mail from 9am to 5pm, Monday to Saturday. The provider's website was available 24 hours a day.
- The service gathered feedback from patients through an online review website. Where there was negative feedback received, we found that the provider had responded to these in a timely way.
- The provider had developed their website to make it easily accessible from a number of different devices, including mobile phones.
- There was a complaints policy which provided staff with information about handling formal and informal complaints from patients and information on the website for patients.

Are services well-led?

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

Summary of findings

There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions but these did not always operate effectively.

- Identification checks did not provide assurance that the patient was who they said they were, whether they were male or female or over the age of 18.
 - On the day of the inspection employer liability, public liability and adequate professional indemnity insurances were not in place.
 - At the time of the inspection a confidentiality policy was in place. However in the staff recruitment and personnel files that we looked at there was no evidence to show that staff confidentiality had been addressed.
 - We did not see evidence of consent by patients when they were prescribed medicines for use outside of its license to acknowledge and accept that they understood this.
 - GPs conducting consultations did not have oversight of changes to consultation templates following medical alerts and updated evidence base clinical guidance.
 - The safeguarding policy did not have a named person as the lead. Post inspection we received information that a GP with the appropriate level training had been nominated as the safeguarding lead.
 - Disclosure and Barring Service (DBS) checks were not up to date for all staff.
 - The provider held twice yearly governance meetings which were the only meetings that were minuted. However, as the management team, clinical team and IT teams worked closely together there was ongoing discussions at all times about service provision.
 - Systems were in place to ensure that all patient information was stored securely and kept confidential.
 - 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.
-

Index Medical Limited

Detailed findings

Background to this inspection

Background

Index Medical Limited is based in Westbury-on-Trym, Bristol. Index Medical Limited set up an online service in January 2010 which includes a remote consultation with a GP. We did not inspect the provider's affiliated pharmacy which is based in Scotland. We inspected both online services known as Dr Fox online doctor and pharmacy and Fast Doctor at the following address where the provider is registered to provide services from:

60, City Road, St Pauls, Bristol, BS2 8TX

At the time of the inspection there were two directors of the service supported by three contracted GPs and they also employed an administrative manager and a customer services assistant. Dr Fox and Fast Doctor had approximately 200,000 patients registered. Since its launch there have been approximately 500,000 requests for prescriptions. The service can be accessed through their websites, www.doctorfox.co.uk and www.fastdr.com where patients can place orders for medicines. The service is available for patients in the UK and in the EU. Patients can access the service by phone or e-mail from 9am to 5pm, Monday to Saturday.

The service is not intended to be used in an emergency and patients under the age of 18 are not treated. On the website patients select the medicine they wish to be prescribed and then complete a consultation questionnaire. Patients do not have to pay to register with the service in order to do this. Patients pay for their medicines when making their on-line application. If approved by the prescriber, medicines via the Dr Fox website are dispensed, packed and delivered by a third party tracked and secure courier service. Medicines prescribed via the Fast Doctor website

are collected from an affiliated pharmacy chosen by the patient at the time of ordering. In the event that GPs reject a prescription request, refunds are made to the patient at this point.

Index Limited is registered with Care Quality Commission (CQC) and have a registered manager 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 second CQC Inspector, a Pharmacist Inspector and two GP Specialist Advisors.

Before visiting, we reviewed a range of information we hold about the service.

During our visit we:

- Spoke with the two directors, two GPs and the governance manager.
- Reviewed organisational documents.
- Reviewed the organisation's websites.
- Reviewed a sample of 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?

Detailed findings

- 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 in place to ensure that all patient information was stored and kept confidential. All patient data moving between systems was encrypted but not at rest. ('Data at rest' prevents an unencrypted copy of the database being physically stolen). Developments had been put into place to ensure "data at rest" was also encrypted by migrating the data to two new servers and we were told this would be completed within two months. The provider ran vulnerability scans of their system every three months to identify any unusual access. At the time of the inspection the provider did not have a confidentiality policy in place. Post inspection we received a copy of a confidentiality statement that staff would be asked to sign but no evidence was supplied to demonstrate that this had been read, understood and signed by staff.

There were processes in place to manage any emerging medical issues during a consultation. The service was not intended for use by patients with chronic conditions other than asthma or as an emergency service. However the provider's website did not state that the service was not for use in an emergency.

On registering with the service, patients were advised to ensure they entered accurate information and not to create duplicate accounts. This advice, with reasons given, was repeated at the start and the end of consultations, at the order confirmation stage, and in correspondence emails. Credit card checks were not undertaken by the provider unless orders were placed for over the amount of £250. The provider's website stated that payment could be made using a payment card with different cardholder details from that of the Dr Fox account holder. We also saw from the provider's website that patients could request delivery of their medicines to an address other than the one the patient registered with. This system did not provide assurance that the patient was who they said they were; whether they were male or female; over the age of 18; or ordering medicines for themselves. We saw evidence that the provider had undertaken a risk assessment that related to identity checks. Measures were in place to prevent over-ordering and duplicate accounts. All newly registered

accounts were scrutinised and if similarities were identified, the accounts were amalgamated and the patient notified. Medicines supplied had to be signed for on delivery and PO boxes or collection depot services were not allowed. Clinicians had access to the patient's previous records held by the service. The service did not treat patients under the age of 18.

Prescribing safety

Medicines prescribed to patients were monitored by the provider to ensure prescribing was appropriate. On the website patients selected the medicine they wished to be prescribed and then completed a consultation questionnaire. If a medicine was clinically appropriate following a request, the GP was able to issue a private prescription to patients. The GPs could only prescribe from a set list of medicines that were advertised on the provider's website. There were no controlled drugs on this list. 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.

We asked how the provider ensured that they followed current prescribing guidelines. The medical director told us that the consultation forms on the websites were set up in line with evidence based guidance, for example National Institute for Health and Care Excellence (NICE) guidance. 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 and links to further health promotion and advice.

The consultation questionnaires had been reviewed in 2016 by a GP, who was registered with the GMC and had a license to practice, to ensure they still met evidence based practice guidance. However there was no formal review programme in place or oversight. Post inspection we received evidence that this was going to be implemented with oversight from the GPs with a license to practice working for the service.

The provider prescribed antibiotics for a small range of conditions. There were strict timeframes in place for the issuing of repeat prescriptions, for example, prescribing of antibiotics for the treatment of acne had been restricted to four months' supply.

The provider issued reliever inhaler prescriptions for asthma, based on information supplied by the patient to

Are services safe?

show that they had previously been prescribed the medicine. Up to two inhalers could be requested in one transaction but patients could not make more than one request in three months. If requesting more than this, patients were asked to provide their GP details and consent to inform them of the supply. Without consent to inform the patient's GP, the medicine would not be prescribed. However this meant that patients could be supplied with up to eight inhalers over a 12 month period without informing their GP of the supply. We saw evidence of this in patient records. Using reliever inhalers regularly can be a sign of poorly controlled asthma, which can lead to an asthma attacks. We raised this as an area of concern with the provider who immediately changed the maximum quantity of inhalers that could be supplied to one and also added a requirement that the patient's GP must be informed of every supply.

We looked at a sample of patient records. We saw that any queries which were identified by the GP before prescribing were resolved by requesting further information from the patient and by the use of a notes system in the patient's medical record. This provided a contemporaneous record of all prescriptions requested, declined and supplied alongside accompanying notes.

The service 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 consultation form to explain that the medicines were being used in an unlicensed way and the patient had to acknowledge that they understood the information. Additional information, to guide the patient when and how to take these medicines was provided with the medicine. We did not see evidence that the patient had specifically acknowledged this and consented to the implications of this for these medicines. However we were told that patients had to agree to terms and conditions and read the important information pages that detailed information regarding use of medicines for unlicensed indications.

If a patient was using the Fast Dr website they were able to choose an affiliated pharmacy where they would like their prescription dispensed from. If the Dr Fox website was used, medicines were delivered directly to the patient by secure, tracked and signed for delivery 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. We reviewed four incidents and found that these had been fully investigated, discussed and as a result action taken in the form of a change in processes. For example: following a concern that patients were not replying or acknowledging receipt of important information sent by a GP via the messaging feature, the provider made changes to the website to ensure that at login, patients were unable to access the consultation page until they had acknowledged the message from the GP. Significant events were discussed at the six monthly governance meeting with all staff, where learning was documented.

We saw evidence which demonstrated the provider was aware of and complied with the requirements of the Duty of Candour by explaining to the patient what went wrong, offering an apology and advising them of any action taken.

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 and consultation templates amended where necessary. However we were told that a doctor without a license was making these amendments. Prescribers were informed if the consultation form had been updated. Post inspection, we received evidence of a revised policy that ensured clinical oversight from the GPs. There was no process within the organisation to review patients who may have been prescribed medicines which were the subject of these alerts. We saw that one alert had been responded to appropriately however we also saw that two other alerts had been missed and appropriate action had not been taken.

Safeguarding

Staff had received training in safeguarding and whistleblowing and knew the signs of abuse and to whom to report them. All staff had access to safeguarding policies and could access information about who to report a

Are services safe?

safeguarding concern to. The safeguarding policy did not have a named person as the lead. A GP interviewed stated that they presumed the safeguarding lead was the medical director. Post inspection we received information that a GP with the appropriate level training had been nominated as the safeguarding lead.

Staffing and Recruitment

At the time of the inspection the provider told us that there were enough staff, including GPs, to meet the demands for the service and there was a rota for the GPs. There was a support team available to the GPs during consultations and a separate IT team.

The provider had a selection process in place for the recruitment of all staff. We reviewed four recruitment files which showed the documentation that was available. However we saw that the Disclosure and Barring Service (DBS) check for one GP had not been renewed since 2004. (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 provider told us that they were working with the local city council to provide Index Medical Ltd with the checking service and were waiting for this to be finalised.

We were told that inductions took place but the provider was unable to provide evidence of this. The provider kept records for all staff including the GPs but there was no system in place that flagged up when any documentation was due for renewal such as their professional registration or DBS check. We also found that two of the GPs working for the service did not have appropriate professional indemnity insurance. We received evidence post inspection that this was now in place. The provider did not have

confirmation of level three safeguarding training by the GPs. This was provided post inspection. GP candidates had to be registered with the General Medical Council (GMC) and have a license to practice. All candidates were on the GMC GP register and had received their appraisal.

Monitoring health & safety and responding to risks

All clinical consultations were rated by the GPs for risk. For example, if the GP thought there may be serious mental or physical issues that required further attention patients would be signposted to the patient's own GP. 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 secure operating system.

The provider had risk assessed all areas of potential prescribing by the service and taken the decision not to provide medicines for chronic diseases other than asthma. Pain relief medicines with a recognised potential for abuse were also not prescribed in order to reduce risk. We were told that in other areas, for example, contraceptives and a treatment for acne medicines, these would not be supplied without a patient's permission to notify the patient's own GP.

Patients were not treated on the registered premises and GPs carried out the online consultations remotely, usually from their home or surgery. Administrative staff also worked from their own homes. However we found that the location where regulated activities were registered had no business insurance or public liability insurance. We also found that the provider had no employee liability insurance in place, which is a legal requirement. We told the provider of our concerns and we received, the day following the inspection, confirmation that all insurances were now in place.

Are services effective?

(for example, treatment is effective)

Our findings

We found that this service was 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 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 medicines was known in advance and paid for at the point of ordering. No charge was made for the consultation. The costs of any resulting prescriptions were handled by the administration team.

Staff understood and sought patients' consent to care and treatment in line with legislation and taking into account guidance.

All GPs/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. Where a patient's mental capacity to consent to care or treatment was unclear the GP declined to prescribe the medicine and signposted the patient to the patients own GP.

Assessment and treatment

We reviewed ten examples of medical records that demonstrated that 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.

We were told that the review of each online questionnaire for repeat medicines, which enabled the GP to make a decision whether to prescribe or not, lasted for about a minute. For a first order the length of the review depended on the complexity of the case. If the GP had not reached a satisfactory conclusion there was a system in place where they could contact the patient back. We saw that over a week period, dialogue was entered into with approximately six different patients to follow up on areas that required clarity following completion of the online consultation form.

The provider used consultation questionnaires which were specific to treatments and medicines supplied. Each treatment area had its own bespoke online consultation. Each treatment area also had information pages which formed part of the consultation process. The consultation questionnaires updated with advisory text as the questionnaire was completed. The patient would be informed if the service was unable to supply the medicine and the patient would be advised to consult with their own GP. We reviewed ten medical records which were complete records and adequate notes were recorded. The GPs had access to notes of previous consultations with the service.

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 a patient needed further examination they were directed 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.

The service monitored consultations and carried out consultation and prescribing audits to improve patient outcomes. We were shown evidence that an audit of 20 consecutive prescriptions issued by each individual GP who worked for the service had taken place within the last two months. Audit results showed that prescribing protocols had been adhered to, no adverse events had resulted and patients had been messaged appropriately.

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. If patients agreed we were told that a letter was sent to their registered GP in line with GMC guidance. We were told that approximately 1000 letters were sent to patients' own GP each month and we saw examples of these. This system had resulted in several instances whereby the patients own GP had asked the provider not to prescribe as the patient needed advanced management.

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 (or links to NHS websites or blogs). For example: a student health page including sexual health advice, stop smoking advice. A medical information page was available

Are services effective?

(for example, treatment is effective)

for each condition the service prescribed medicines for. For example, advice for patients requesting inhalers for asthma included the need to visit their GP regularly for a review and how to recognise signs of worsening asthma and when they should contact their GP.

Staff training

Staff received induction when recruited and we were told that this included confidentiality, required training and shadowing. However there was no record of this having taken place. All staff had completed online safeguarding and whistleblowing training.

Administration staff received regular performance reviews annually and one to one meetings every three months. All the GPs had to have received their own appraisals before being considered eligible at recruitment stage. We saw evidence that all GPs had received appraisals in the past 12 months.

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 usually at their own home

We did not speak to patients directly on the days of the inspection. However, we reviewed the latest survey information.

An independent survey conducted via Trusted Shops showed:

That in the previous 12 months approximately 3000 reviews had been received and that 99% of reviewers found the

services to be excellent or good. At the end of every consultation, patients were sent an email asking for their feedback. An amalgamation of patient comments gave the following results:

- 94% of patients stated that they were extremely happy or happy with the service.
- 94% of patients found the health information available on the website as extremely or very useful.

Involvement in decisions about care and treatment

Patient information guides about how to use the service and technical issues were available. There was a dedicated team to respond to any enquiries. A survey of 53 patients who had queries about the service 93% stated that the service was extremely or very effective at responding to these.

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

The service could be accessed through their websites, www.doctorfox.co.uk and www.fastdr.com where patients could place orders for medicines. The service was available for patients in the UK and in the EU. The website made it clear to patients requesting medicines from the EU regarding the regulations relating to medicines that were not available. Patients could access the service by phone or e-mail from 9am to 5pm, Monday to Saturday and on line 24 hours a day and seven days a week. This was not an emergency service. Subscribers to the service paid for their medicines when they made their on-line application. Once approved by the prescriber, medicines prescribed via the Dr Fox website were dispensed, packed and posted and delivered by a third party courier service. Medicines prescribed via the Fast Doctor website were collected from an affiliated pharmacy chosen by the patient at the time of ordering.

Following dispensing of medicines patients were contacted to follow up on the effectiveness of the treatment and to ask for feedback about the service.

The provider had developed the website to make it easily accessible from a number of different devices, including mobile phones.

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 other than children under the age of 18, to whom services were not provided.

GPs that were available were listed on the services website along with their General Medical Council registration numbers.

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. A specific form for the recording of complaints has been developed and introduced for use. We reviewed the complaints system and noted that comments and complaints made to the service were recorded. We reviewed two complaints out of five received in the past 12 months. Trends were analysed at the six monthly governance meetings. We noted that the five complaints received in the last 12 months all related to delivery issues. The provider had met with the courier service to resolve these issues.

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

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. We reviewed business plans for the next year which included IT development.

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. We saw that these had been reviewed and updated regularly.

There were a variety of checks in place to monitor the performance of the service. The information from these checks were discussed informally on a daily basis and formally at the six monthly governance meeting. Minutes of the governance meetings demonstrated that all aspects of the business were discussed.

There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions but these did not always operate effectively. For example, on the day of the inspection we found:

- Identification checks did not provide assurance that the patient was who they said they were, whether they were male or female or over the age of 18.
- At the time of the inspection a confidentiality policy was in place. However in the staff recruitment and personnel files that we looked at there was no evidence to show that staff confidentiality had been addressed.
- Employer liability, public liability and adequate professional indemnity insurances were not in place.
- 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.
- GPs conducting consultations did not have oversight of changes to consultation templates following medical alerts received and updated evidence base clinical guidance.

- The safeguarding lead had not undertaken appropriate training.
- Disclosure and Barring Service (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) were not up to date for all staff.
- We were told that communication between staff members was regular but informal. Only the six monthly governance meeting were minuted.

We did see that:

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

Leadership, values and culture

The Medical Director and IT director had overall responsibility for the service. Administrative support was provided by a governance manager and administrator. Both were available to the service daily. There were systems in place to address any absences. Administrative support was provided by a governance manager and administrator.

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.

Staff told us that there was an open relationship with their employers and that it was a very positive culture to work in.

Safety and Security of Patient Information

There were policies and IT systems in place to protect the storage and use of all patient information. The IT systems were also in the process of being upgraded. The service could provide a clear audit trail of who had access to records and from where and when. Both the service and the GPs were 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

Are services well-led?

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

Patients had the opportunity to rate the service on an online system called “Trust pilot” which was an open system provided by a third party supplier. At the end of every consultation, patients were sent an email asking for their feedback. Patient feedback was published on the service’s website. Actions were taken as a result of patient feedback. For example, the provider worked with the company who delivered the medicines to improve the ability to track parcels more effectively.

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.

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.

Staff told us that the team meetings were the place where they could raise concerns and discuss areas of improvement. These took place six monthly for the whole organisation. Staff were also given this opportunity during appraisals and one to one meetings. However, as the management team and IT teams worked closely together there was ongoing discussions at all times about service provision.

We saw that plans were in place to improve the web interface for accessing consultations and prescribing and also improving features for patients on the website. The provider was also considering partnering with another health service for the benefit of patients.

This section is primarily information for the provider

Requirement notices

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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment</p> <p>Care and treatment must be provided in a safe way for service users.</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">The provider did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users in relation to identity checks. <p>This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance</p> <p>Providers must operate effective systems and processes to make sure they assess and monitor their service.</p> <p>How the regulation was not being met:</p>

This section is primarily information for the provider

Requirement notices

The provider had failed to assess, monitor and mitigate risk relating to the health, safety and welfare of service users and others who may be at risk which arise from carrying out on the regulated activity in relation to:

- Ensuring appropriate insurances were in place.
- Ensuring DBS checks were up to date.
- Ensure systems and processes were in place to protect patient's confidentiality.
- Ensuring amendments to consultation templates had oversight from licensed to practice clinicians.

This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.