PrivateDoc Limited

PrivateDoc Limited

Inspection report

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Ratings

Overall rating for this service	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Inadequate
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Overall summary

Letter from the Chief Inspector of General Practice

We rated this service as Inadequate overall.

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Inadequate

Are services caring? – Inadequate

Are services responsive? – Inadequate

Are services well-led? – Inadequate

We carried out an announced comprehensive inspection of PrivateDoc Limited on 10 May 2017 and found that the provider was not providing safe, effective and well led care in accordance with the requirements of the Health and Social Care Act 2008. We issued Requirement Notices and a Warning Notice to the provider to drive improvement.

We undertook a desk-based review on 3 August 2017 to check that the provider had followed their action plan and to confirm that the requirements of the Health and Social Care Act 2008 had been met following our Warning

Summary of findings

Notice. Following the review on 3 August 2017 we found that the provider had responded appropriately to our findings and had met the requirements set out in our enforcement action.

We carried out an announced comprehensive inspection on 25 January 2018 and found the improvements made had been embedded.

The full comprehensive reports for all of our previous inspections can be found by selecting the 'all reports' link for PrivateDoc Limited on our website at www.cqc.org.uk.

We carried out an announced comprehensive inspection at PrivateDoc Limited on 1 July 2019. Following that inspection, CQC received a number of concerns raised by an individual via our National Customer Service Centre and following a review of those concerns, it was decided to carry out a second announced visit on 15 July 2019 as part of this inspection.

PrivateDoc Limited was originally established in 2012 to provide an online service that allows patients to request prescriptions through a website. Patients are able to register with the website, select a condition they would like treatment for and complete a consultation form. This form 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 (which we do not regulate) for the medicines to be supplied.

At this inspection we found:

- The provider's process for completing patient identification checks was ineffective and we could not be assured the prescriptions were being issued to and delivered to the named account holder.
- We found evidence the provider had knowingly ignored patient identification concerns and proceeded to prescribe medicines to patients whom they knew were not the named account holder.
- We found flaws in the provider's system which allowed patients to overwrite information in the medical record such as their height, weight and body mass index when requesting weight loss medicines.
- When prescribing weight loss medicines off license there was no evidence of discussions with the patient to advise them of the off license prescribing.
- We found patients were provided with clinical advice by a non-clinical member of staff who had received no prior training on the medicines they were providing advice for.
- 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.
- Each medicine available on the website was accompanied by additional information provided by the GP or medical director.
- The provider did not have a process for recording, handling and sharing learning from safety incidents. The provider told us they did not have any safety incidents since starting services, however, we found this was not the case.
- We found that staff recruitment checks were not always completed.
- There was no documented evidence or audit trail of the clinician's rationale for approving or declining each prescription request.
- When patients were not accepted for treatment they were not given any advice or information on why they were not suitable for treatment or where they could receive treatment.
- The service did not have evidence of any quality improvement systems.
- The provider was registered on Trustpilot, (an online patient feedback and review service) and encouraged patients to provide feedback. The provider was rated as "Excellent" and five stars from 1,524 reviews.
- The process for recording, handling and learning from complaints and feedback was not effective. Of the complaints that we reviewed, we were unable to review a complete cycle of the complaint and review both the initial complaint and response. In addition to this, complaints were responded to informally and no escalation routes were provided to the patient.
- We found there was not effective governance structures and systems in place.
- The provider had created a system which allowed patients to pick their GP practice from a list or map based upon their postcode in order to try and encourage patients to consent to sharing information with their GP.

Summary of findings

- The service did not have a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading.

The area where the provider **must** make improvements as they are in breach of regulations are:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The areas where the provider **should** make improvements are:

- Review and improve systems to conform with General Pharmaceutical Council guidance on prescription only medicines.
- Implement a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that the provider cease trading.

Following this inspection, CQC has taken urgent enforcement action and we have imposed conditions on the providers registration.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

Special measures will give people who use the service the reassurance that the care they get should improve.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

PrivateDoc Limited

Detailed findings

Background to this inspection

PrivateDoc 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: Unit 7, Wharfside House, Prentice Road, Stowmarket, Suffolk, IP14 1RD.

PrivateDoc Limited was originally established in 2012 to provide an online service that allows patients to request prescriptions through a website. Patients are able to register with the website, select a condition they would like treatment for and complete a consultation form. This form is then reviewed by a GP and a prescription is issued if appropriate. The GPs were sub-contracted. 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 (which we do not regulate) for the medicines to be supplied.

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

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

On both inspection visits, 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 patient records.

We did not speak with any patients as part of the inspection, but reviewed feedback collected by the provider.

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.

Inadequate

Are services safe?

Our findings

We rated the provider Inadequate for providing safe services because:

- The provider's process for completing patient identification checks was ineffective and we could not be assured the prescriptions were being issued to and delivered to the named account holder.
- We found evidence that the provider had knowingly ignored patient identification concerns and proceeded to prescribe to patients whom they knew were not the named account holder.
- We found flaws in the provider's system which allowed patients to overwrite their initial height, weight and body mass index when requesting weight loss medicines.
- We found the provider did not clearly document the rationale for approving or declining prescription requests, including when prescribing medicines off license and there was no evidence of discussions with the patient to advise them of the off license prescribing.
- The provider did not have a process for recording, handling and sharing learning from safety incidents. The provider told us they did not have any safety incidents since starting services, however, we found this was not the case.
- We found that staff recruitment checks were not always completed.

Keeping people safe and safeguarded from abuse

Staff employed at the headquarters had received training in safeguarding and knew the signs of abuse. All staff had access to the safeguarding policies and where to report a safeguarding concern. All the GPs had received adult and child level three safeguarding training. It was a requirement for the GPs registering with the service to provide evidence of up to date safeguarding training certification. We reviewed two safeguarding referrals the provider had made and found they were made correctly and in a timely manner.

The service had a policy and did not provide regulated activities to children.

Monitoring health & safety and responding to risks

The provider headquarters was located within modern offices which housed the IT system. Patients were not treated on the premises as GPs carried out the online consultations remotely; usually from their home.

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

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

A clinical meeting was held with staff, where standing agenda items covered topics such as service issues, case reviews and clinical updates. We saw evidence of meeting minutes to show where some of these topics had been discussed.

Staffing and Recruitment

There was enough staff, including GPs, to meet the demands for the service. There was a medical director, prescribing GP, a GP employed to complete consultation reviews and a separate IT team. The prescribing doctors were paid on a per consultation basis.

The provider had a selection and recruitment process in place for all staff. There were a number of checks that were required to be undertaken prior to commencing employment, such as 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.)

The service could not evidence recruitment and staffing checks and processes were always completed. For example, we found the provider had not completed reference requests for a newly recruited member of staff. The provider told us they did not feel it was necessary to do so. Following the inspection, the provider told us they had reviewed their recruitment processes to ensure appropriate checks were undertaken.

Potential GP employees had to be currently working in the NHS, be registered with the General Medical Council (GMC)

and on the National Performers List. They had to provide evidence of having professional indemnity cover, an up to date appraisal and certificates relating to their qualification and training in safeguarding and the Mental Capacity Act.

Prescribing safety

Medicines were prescribed to patients from online forms which were monitored by the provider to ensure prescribing was evidence based. Patients selected a medicine from a set list which the provider had risk-assessed. There were no controlled drugs on this list. The service did not prescribe medicines for use in an emergency. Every request was reviewed by a GP who could contact the patient for further information. If the request was approved the GP could issue a private prescription which was dispensed by the affiliated pharmacy.

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 service prescribed a medicine for the treatment of hair loss which was not licensed for this purpose. Medicines are given licences after trials have shown they are safe and effective for treating a particular condition. Use of a medicine 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 medicine was being used outside of the licence, and the patient had to acknowledge that they understood this information. Additional written information to guide the patient when and how to use these medicines safely was supplied with the medicine. However a medicine for weight loss was prescribed to some patients outside the terms of the product licence and there was no evidence that patients were provided with information or gave their consent to this.

The service only offered one antibiotic, for use in acne in line with national guidance. Patients were asked to provide a photograph so that the doctor could confirm the prescription was appropriate.

Some medicines such as oral contraceptives and medicines for erectile dysfunction could be ordered on repeat prescription. There were limits on the number of repeats and the review period for each condition, after which the patient was required to complete a full consultation questionnaire before a further prescription was issued. Other conditions such as asthma and weight loss required a full questionnaire for every order.

The service did not prescribe any medicines which required routine blood tests. When requesting medicines for long term conditions such as asthma and oral contraception patients were asked to confirm that they were monitored regularly by their usual GP. The service prescribed asthma inhalers on a one-off basis for patients who could not conveniently get a prescription from their usual GP, and only when the patient provided their GP contact details so that the service could write to inform them of the prescription.

The service offered weight loss medicines including one administered by injection. Patients updated their weight and other information each time they requested a prescription, and this information was available to the doctor in graph form, to allow them to monitor progress. However, we found that when a patient registered, if they entered a BMI lower than 30, the patient was contacted by text and asked to reconfirm their height and weight. When a patient reconfirmed the figures, the second figure entered overwrote the first figure and there was no audit trail of the first figure entered. Therefore, the patient was able to change their height, weight and BMI without the knowledge of the provider. Following the inspection, the provider told us they had made changes to their IT system to prevent the possibility of this occurring in the future.

We found that prescriptions were issued to patients who had an initial BMI of under 30. The medicine is licensed for use in patients with an initial BMI of 30 or higher, or a BMI of 27 or higher with another risk factor such as high blood pressure. The prescriber's rationale for prescribing the medicine to patients with an initial BMI of less than 30 was not documented.

After the first prescription of the injectable product, the provider contacted the patient to see if they were managing the injections, whether there were any side effects and whether the medicine was effective. The follow up call was in the form of a structured questionnaire and the answers were documented in the clinical record. However, we found at times follow-up consultations were completed by a non-clinical member of staff, although the provider's recorded introductory telephone message advised they were speaking to a member of the clinical

team. The provider's process was that these were to then be reviewed by a clinician. We found there was no audit trail to evidence the date and time that these consultations were reviewed by a clinician.

Following the inspection, the provider told us that follow-up consultations would only be completed by a clinician. This will be reviewed at the next inspection.

Prescriptions were dispensed by an affiliated pharmacy and distributed by a courier service. The service had a system in place to assure themselves of the quality of the dispensing process. Patients could track the progress of their order using their secure account.

Information to deliver safe care and treatment

On registering with the service, the provider had processes to verify patient identity. However, we found that these processes in place were not effective.

We reviewed patient consultation records and found a patient had contacted the service to inform that an account had been set up in their name fraudulently, and that their bank card had been used to make a purchase on the website without their consent. The patient told the service to not deliver the medicines, however, we found that the provider ignored the concerns raised by the patient and staff. Despite having a complete awareness that this prescription was fraudulently obtained the provider contacted the delivery company and told them to redeliver the parcel to the patient. The parcel was eventually returned to PrivateDoc as the patient refused to accept it. We subsequently found when the account was registered, there was a discrepancy with one of the personal details, however, this did not result in any additional checks being carried out.

We found another patient registered with the service and had a prescription issued despite a clear typographical error in their surname. No subsequent checks were completed to verify the patient's identification and the provider did not undertake any investigation into this error.

We reviewed recorded telephone conversations between patients and the service and found that the service did not ask any security questions prior to discussing clinical issues with the patients, which meant the provider could not be assured they were speaking to the correct individual.

Following the inspection, the provider told us they had strengthened their identity checking processes by ensuring any registration details which were not a complete match with the identity checking software were followed up, and prescriptions would only be issued to patients with a fully confirmed identity. This will be reviewed at the next inspection.

Management and learning from safety incidents and alerts

There was no systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. The provider did not have a policy or process in place for managing safety incidents and alerts and told us they did not believe any safety incidents had occurred.

We saw evidence from reviewing patient consultation records and speaking to staff that incidents did occur, however, the provider was unable to evidence actions taken in relation to these incidents and we found subsequent approved prescription requests which did not take into account previous incidents involving the same patients.

The service received medicines safety alerts which were reviewed by a pharmacist and shared with clinical staff. However, the alerts received weren't documented consistently in line with the provider's policy and the records were incomplete. In addition to this, we found where the provider had provided a prescription for an oral contraceptive, the provider did not enquire if the patient was prescribed Sodium Valproate, despite recent patient safety alerts.

Following the inspection, the provider told us they had made improvements to how they respond to patient and medicine safety alerts and had incorporated the alerts into their clinical system. This will be reviewed at the next inspection.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

We rated the provider as Inadequate for providing effective services because:

- We found patients were prescribed medicines despite fluctuating Body Mass Index (BMI) entries made by the patient in short periods of time.
- We found patients were provided with clinical advice by a non-clinical member of staff who had received no prior training on the medicines they were providing advice for.
- There was no documented evidence or audit trail of the clinician's rationale for approving or declining each prescription request.
- The service did not have evidence of any quality improvement systems.
- The service's consultation review process was ineffective and failed to highlight issues and concerns which we found on the day of the inspection.

Assessment and treatment

Patients completed an online form which included their past medical history. There was a set template for each medicine requested for the consultation that included the reasons for the consultation. If the GP had not reached a satisfactory conclusion there was a system in place where they could contact the patient again for further information.

We reviewed six approved and six rejected consultation records for a weight loss medicine and found in all consultations records we reviewed, there was no documented evidence or audit trail of the clinician's rationale for approving or declining each prescription request.

We found a patient requested two orders of a weight loss medicine. Following telephone conversations with the patient it was established that this order was placed on behalf of other people, therefore this order was rejected. Two days after this event, another order of a weight loss medicine was placed for a different quantity, approved and delivered to the same patient with no subsequent checks completed to verify the patient's identification or whom the prescription was for. This was despite clear evidence on the patient records of the earlier rejected prescription request in addition to a fluctuation in Body Mass Index (BMI) entries made by the patient during the ordering process. There was no documented evidence or audit trail of the clinician's rationale for approving the prescription request or whether they had considered this information.

The service had a system in place to review 7% of consultation records and employed an independent GP who was paid per consultation review. We found this system was ineffective and failed to highlight issues which we found on the day of the inspection.

Since the previous inspection, the provider had implemented a system of follow-up consultations for patients prescribed a weight loss medicine. We found where follow-up consultations were completed by a non-clinical member of staff, clinical advice such as dosages were discussed with the patient and the non-clinical member of staff was providing patients with recommendations on how to increase their dosages. In addition to this, we found evidence of the non-clinical member of staff providing patients with clinical advice without any training or awareness of this medicine.

Since the previous inspection, the provider had made changes to their IT systems to enable both the consultation and dispensing processes to be managed via one single platform. The provider told us this meant the system was more dynamic and changes could be made more easily.

Quality improvement

The service did not have evidence of any quality improvement systems such as audits resulting in changes made to support the quality of care provided. This ineffective quality improvement program had failed to ensure the service identified areas of poor performance which impacted on outcomes for patients.

Staff training

The induction process was limited, and we found a member of staff had not received training on information governance despite having access to confidential patient information.

All the GPs had to have received their own General Medical Council appraisal before being considered eligible at recruitment stage.

Coordinating patient care and information sharing

All patients were asked for consent to share details of their consultation and any medicines prescribed with their

Inadequate

Are services effective?

(for example, treatment is effective)

registered GP on each occasion they used the service. The provider had created a system which allowed patients to pick their GP practice from a list or map based upon their postcode in order to try and encourage patients to consent to sharing information.

Patients selected a medicine from a set list which the provider had risk-assessed. There were no controlled drugs on this list. The service did not prescribe medicines for use in an emergency. Where patients agreed to share their information, we saw evidence of letters sent to their registered GP in line with GMC guidance. We found there was no clear risk assessment in place relating to when it would be appropriate to decline to prescribe in the event of a lack of consent to share information about the prescribing with a patient's GP.

The service did not prescribe any medicines which required routine blood tests and did not offer any medical tests or referrals.

Supporting patients to live healthier lives

The service had a range of information available on the website (or links to NHS websites or blogs). Each medicine available on the website was accompanied with additional information provided by the GP or medical director.

For example, smoking cessation medicines were accompanied with information such as:

- What are the immediate health risks?
- The benefits of quitting smoking
- What help is available to quit smoking?
- Prescription only medication to help with stopping smoking

Inadequate

Are services caring?

Our findings

We rated the provider as Inadequate for providing caring services because:

- We found only patients who had been successful in obtaining a prescription were automatically offered to provide feedback via Trustpilot and patients who had been declined were not offered the opportunity to do so. The service had no other evidence of patient satisfaction.

Compassion, dignity and respect

We were told that the GPs undertook online consultations in a private room and were not to be disturbed at any time during their working time.

We did not speak to patients directly on the days of the inspection. However, we received contact from patients prior to the inspection and we reviewed online patient reviews. At the end of every approved consultation, patients were sent an email asking for their feedback through Trustpilot.

Patients told us of their satisfaction with the service including how they felt the service operated a quick, discreet and respectful service.

Involvement in decisions about care and treatment

Patient information guides about how to use the service and technical issues were available.

Patients had access to information about the clinician who reviewed their consultation record. Patients were able to access their consultation records through their personalised online account on the provider's website.

The provider had not completed a patient survey, however, the provider was registered on Trustpilot and encouraged patients to provide feedback. The provider was rated as "Excellent" and five stars from 1,524 reviews. Recent reviews included compliments on the speed of the consultation process and delivery.

We found only patients who had been successful in obtaining a prescription were automatically offered to provide feedback via Trustpilot and patients who had been declined were not offered the opportunity to do so.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the provider as Inadequate for providing responsive services because:

- Patients were not provided with the reasoning for any prescription rejection which meant that patients were not given any advice or information on why they were not suitable for treatment.
- The process for recording, handling and learning from complaints and feedback was not effective. Of the complaints that we reviewed, we were unable to review a complete cycle of the complaint and review both the initial complaint and response. In addition to this, complaints were responded to informally and no escalation routes were provided to the patient.

Responding to and meeting patients' needs

Access via the website to request a consultation was available all day every day. 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 could access the service through a desktop computer, laptop or mobile phone device.

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

The provider offered free next day delivery on all prescriptions and advised that orders approved prior to 1pm would usually be dispensed on the same day. Following feedback from patients, the provider changed their delivery company, this resulted in less complaints but the system had not been formally reviewed.

The provider made it clear to patients what the limitations of the service were. However, we found in all of the rejected consultation records we reviewed, the service did not inform patients of the reasoning for the rejection and simply signposted them to their GP. This meant that patients were not given any advice or information on why they were not suitable for treatment or provided with further advice on how they would be able to live healthier lives.

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.

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.

We found the process for managing and responding to complaints was not effective. The provider was unable to provide a complete cycle of complaints; from the initial complaint, investigation, response and learning. We found complaints were responded to informally with no escalation processes. There was no evidence of learning from complaints communicated amongst the staff team thus putting patients at risk of similar events reoccurring.

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. The patient was required to enter card details and a payment hold would be placed on the card at the time of requesting. If the consultation was approved, payment would be taken. If the consultation was declined, the payment hold would be removed, and payment would be released back to the patient within 3-5 working days.

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?

Inadequate

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

Our findings

We rated the provider as Inadequate for providing well-led services because:

- We found examples where senior members of staff had knowingly ignored patient identification concerns and proceeded to prescribe to patients whom they knew were not the named account holder.
- We found there was not effective governance structures and systems in place.
- There were minimal checks in place to monitor the performance of the service and we found the provider's review process of consultations was ineffective.
- Care and treatment records were not complete or always accurate and did not contain information on the decision-making process of the clinicians.
- The service did not have a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading. This was raised on a previous inspection visit.
- The service had a limited approach to continuous improvement.

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.

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 and updated when necessary. However, on the day of the inspection, one newly employed non-clinical member of staff we spoke with was not fully aware of the medical emergencies policy and procedure.

We found there was not effective governance structures and systems in place. For example, the systems in place for managing patient safety alerts was ineffective and there was no system in place for recording, managing and learning from safety incidents.

There were minimal checks in place to monitor the performance of the service and we found the provider's review process of consultations was ineffective and failed to highlight any of the issues and concerns we identified during the course of our inspection.

Care and treatment records were not complete and did not contain information on the decision-making process of the clinicians. We also found that care and treatment records were not always accurate due to ineffective patient identification checks and the ability for patients to overwrite consultation data.

Leadership, values and culture

The service was managed by a team of four directors. The service had employed a medical director, a GP, a pharmacist and an independent GP reviewer. The provider had regular management meetings. The practice leadership team were unable to evidence they fully understood the requirements and how to meet them.

The service did not have an open and transparent culture. We found examples where the provider had knowingly ignored patient identification concerns and proceeded to prescribe to patients whom they knew were not the named account holder.

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 were registered with the Information Commissioner's Office. There were business contingency plans in place to minimise the risk of losing patient data.

The service did not have a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading. This was raised on a previous inspection visit. The provider told us they would review these arrangements following the inspection.

Seeking and acting on feedback from patients and staff

The provider had not completed a patient survey other than inviting patients who had been prescribed medicines

Are services well-led?

Inadequate

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

to feedback on Trustpilot. We found only patients who had been successful in obtaining a prescription were automatically offered to provide feedback via Trustpilot and patients who had been declined were not offered the opportunity to do so. Patient feedback was published on the service's 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).

Continuous Improvement

The service had a limited approach to continuous improvement. The provider was unable to evidence effective systems for monitoring and improving the care provided.

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 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** • The provider's process for completing patient identification checks was ineffective and we could not be assured the prescriptions were being issued and delivered to the named account holder. • We found evidence that the provider had knowingly ignored patient identification concerns and proceeded to prescribe to patients whom they knew were not the named account holder. • We found flaws in the provider's system which allowed patients to overwrite their initial height, weight and BMI when requesting weight loss medicines. • When prescribing medicines for weight loss off license there was no evidence of discussions with the patient to advise them of the off license prescribing. • The provider did not have a process for recording, handling and sharing learning from safety incidents. The provider told us they did not have any safety incidents since starting services, however, we found this was not the case. • We found that staff recruitment checks were not always completed. • We found patients were provided with clinical advice by a non-clinical member of staff who had received no prior training on the medicines they were providing advice for. • There was no documented evidence or audit trail of the clinician's rationale for approving or declining each prescription request. • Patients were not provided with the reasoning for the rejection which meant that patients were not given any advice or information on why they were not suitable for treatment. • The service did not have evidence of any quality improvement systems.

This section is primarily information for the provider

Enforcement actions

- The process for recording, handling and learning from complaints and feedback was not effective. Of the complaints that we reviewed, we were unable to review a complete cycle of the complaint and review both the initial complaint and response. In addition to this, complaints were responded to informally and no escalation routes were provided to the patient.
- We found there was not effective governance structures and systems in place.

The enforcement action we took:

CQC has taken urgent enforcement action and we have imposed conditions on the providers registration.