Hexpress Health Support Office

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Overall summary

Letter from the Chief Inspector of General Practice

We rated this service as Requires improvement overall. (Previous inspection May 2019 – Good)

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at Hexpress Health Support Office on 17 May 2022. This was in response to concerns we had received relating to the safety of medicines.

Hexpress Health Support Office (Hexpress) provides an online prescribing service to patients aged 18 years and over. Patients wishing to use the service access it via one of their websites or they can call the service if they are unable to access online services .

At this inspection we found:

- The service prescribed medicines that required monitoring without sufficient reassurances that it was safe for the patient to access or continue with that medicine.
- Safe prescribing policies were not always followed.
- The service routinely reviewed the effectiveness and appropriateness of the care it provided. However, these audits were not always effective.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- Patients could access care and treatment from the service within an appropriate timescale for their needs.

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

- Ensure care and treatment is provided in a safe way to patients
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care

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Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a second CQC inspector, a GP specialist adviser and a member of the CQC medicines team who was working remotely.

Background to Hexpress Health Support Office

Hexpress Health Support Office provides an online prescribing service to patients aged 18 years and over. Patients wishing to use the service access it via one of their websites, where patients fill out their online forms. The questions they are asked will be dependent on the prescription they request or the condition they are seeking treatment for.

They are then required to provide information to verify their identity and complete an online questionnaire relating to their medical history. The information supplied by the patient is then reviewed by one of Hexpress' clinicians and where appropriate, a prescription is issued, and the medicine is dispensed to the patient by Hexpress' own pharmacy, where it is delivered by secure post or if requested sent to a pharmacy nominated by the patient.

How we inspected this service

Before the inspection we gathered and reviewed information from the provider. During this inspection we spoke to the Registered Manager and members of the management and administration team and clinical team.

To get to the heart of patients' experiences of care and treatment, we 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

At our previous inspection in May 2019 we found the service was meeting the requirements of the regulations in providing safe services. At this inspection we found the service was not meeting the requirements for safe care and treatment because their prescribing systems required improvements.

We rated safe as Inadequate because:

Keeping people safe and safeguarded from abuse

Staff employed at the headquarters had received training in safeguarding and whistleblowing and knew the signs of abuse. All staff had access to the safeguarding policies and where to report a safeguarding concern. We were told that the clinicians would search the internet for the respective local authorities' websites dependent on where the patient resided should they need to make a safeguarding referral. All the clinicians had received adult and child level 3 safeguarding training though the service did not offer treatment to children. There was a dedicated email address for staff to use to report safeguarding concerns to the service's internal safeguarding lead.

Monitoring health & safety and responding to risks

The providers headquarters was located within modern offices which housed the IT system and a range of administration staff. Patients were not treated on the premises as clinicians carried out the online consultations remotely; usually from their home. All staff based in the premises had received training in health and safety including fire safety.

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

There were processes in place to manage any emerging medical issues during a consultation. The service was not intended for use by patients during an emergency. 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 or if this was during a consultation the clinicians would raise the alarm or request the customer service staff to do so.

All clinical consultations were rated by the clinicians for risk. For example, if the clinician thought there may be serious mental or physical issues that required further attention. Those rated at a higher risk or immediate risk were reviewed with the help of the support team and clinical director. There were protocols in place to notify Public Health England of any patients who had notifiable infectious diseases.

A range of clinical and non-clinical meetings were held with staff, where standing agenda items covered topics such as significant events, complaints and service issues. Clinical meetings also included case reviews and clinical updates. We saw evidence of meeting minutes to show where some of these topics had been discussed, for example improvements to the patient verification process ,significant incidents and clinical pathways in line with national guidance.

Staffing and Recruitment

Inadequate

Are services safe?

We were told there were enough staff, including clinicians, to meet the demands for the service and there was a rota for the clinicians. There was a support team available to the clinical team during consultations and a separate IT team. The prescribing clinicians were paid on a sessional 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 references and 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.)

Most clinicians were currently working in the NHS and were registered with the General Medical Council (GMC) with a license to practice. However, we were told that due to staff shortages the service was using two EU qualified, registered and licensed doctors to consult with UK patients whilst adhering to UK standards from the General Medical Council (GMC) and limits of British National Formulary and The National Institute for Health and Care Excellence (BNF & NICE). The clinical director advised that the service was supporting these two doctors to become registered with the GMC.

We were told that the EU doctors could only prescribe as part of their role. They had to provide evidence of having professional indemnity cover (to include cover for video consultations), an up to date appraisal and certificates relating to their qualification and training in safeguarding and the Mental Capacity Act.

Newly recruited clinicians were supported during their induction period and an induction plan was in place to ensure all processes had been covered. We were told that the clinicians did not start consulting with patients until they had successfully completed several test scenario consultations.

We reviewed five recruitment files which showed the necessary documentation was available. The provider kept records for all staff including the clinicians and there was a system in place that flagged up when any documentation was due for renewal such as their professional registration. The service conducted on-going checks on all clinicians on a monthly basis.

Prescribing safety

Patients requested medicines using an online form. If a medicine was deemed necessary following a consultation, the clinicians could issue a private prescription to patients that was dispensed via the on- site pharmacy or a pharmacy of the patients' choice. We were told that the clinicians could only prescribe from a set list of medicines which the provider had risk assessed. The prescribing policies detailed that, prior to being prescribed any treatment, patients were informed that should they experience any serious side effects, they should stop taking the medicine immediately, contact their GP, and inform the Organisation. The provider reported that patients also received an automated email at a set interval after using the service asking if they experienced any side effects, as well as other questions for the improvement of the service.

Prior to our inspection we had been notified of four serious incidents that had been reported by stakeholders about patients who had bought medicine from the service. The provider had reviewed the incidents, and this had resulted in them taking a decision not to prescribe a particular medicine. However, we were concerned that the decision only related to the reported medicine. The provider informed us that no other medicines had been identified that were likely to cause harm. Though no risk assessment was provided to support this.

During our inspections we found further concerns relating to prescribing;

Inadequate

Are services safe?

1)The service relied on the patient to confirm that they received regular relevant health checks for the management of long-term conditions with their regular GP, which the service required before prescribing medicines for some long-term conditions. Patients were responsible for ensuring they were providing accurate information about their past medical history. The service did not have effective systems in place to verify relevant information prior to making the decision to treat and prescribe medicines. For example, diabetic patients accessing the service to request medicines for their diabetes, were required to confirm that they had received a recent HbA1C blood test (a blood test that reflects the average blood glucose level over two to three months). Patients were then asked to input their results into the system. The online form used during this process alerted a patient if the results provided were an outlier and therefore the patient could not proceed further with their request for medication. There was potential for the same patient to then enter results that the service deemed acceptable to continue to the next stages of the online form. There was no system that alerted the prescriber if the patient had changed their information. It is our judgement that this system is not safe and possess risk to patient's safety.

The service stated that they did not prescribe certain medicines and for some long term conditions without receiving patient consent to notify the individual's doctor about the prescription. However, we found that the service had continued to issue medicines for a particular patient without receiving any clearance from the patient's own GP or ensuring they had received kidney function tests. We saw no evidence that any information had been requested.

During the factual accuracy period, the provider told us that following our inspection feedback they had on 18 May 2022 ceased the prescribing of ramipril, lisinopril and angiotensin-converting enzyme (ACE) inhibitors that require renal and kidney blood tests and Terbinafine which requires a liver blood test.

2) We found instances where patients requesting antibiotics were prescribed antibiotics without a record of the presenting symptoms or past medical history. For example, in one patient record we reviewed, there was no record of any history of past urine infections or if the patient had a recent urine sample tested. However, a prescription was generated for antibiotics for this patient without a record of the clinical decision to prescribe. Following our inspection, the provider wrote to us stating they would review the process of antibiotics prescribing to ensure it includes the necessary details prior to prescribing.

Following our inspection, we reviewed the providers antibiotic prescribing policy. The policy did not state that a urine sample was required prior to prescribing. However, we are still concerned by the prescribing of antibiotics without sufficient patient history.

3) Patients requesting medicines for weight-loss management, provided their weight. However, the service did not have systems to verify people's current weight, height or BMI. This posed a risk to patient care, as vulnerable patients could access medicines inappropriately.

The service's website listed the conditions it treats and the medicines which were available to treat those conditions.

The service prescribed some medicines off label(refers to the use of medicines outside of the indications for which they are licensed by national regulatory bodies).The policy stated that a doctor would only prescribe off-label if they believed that the medication was effective at treating the condition in question, and that the advantages of taking this medication outweighed the potential risks. There was clear information on the consultation form to explain that the medicines were being used outside of their licence, and the patient had to acknowledge that they understood this information by signing the consultation form.

Inadequate

Are services safe?

There were protocols in place for identifying and verifying the patient and General Medical Council guidance, or similar, was followed. Once prescribed, medicines were typically dispensed via the service's own pharmacy and delivered by secure post. Patients had a choice of requesting prescriptions to be sent to a pharmacy of their choice.

Information to deliver safe care and treatment

On registering with the service, and at each consultation, patient identity was verified. A software application was in place to verify patients' identity and age as part of the online ordering process; if this process found that an individual aged under 18 was attempting to access the service, their order would be automatically rejected, and they would be blocked from the online ordering system. The clinicians had access to the patient's previous records held by the service.

Management and learning from safety incidents and alerts

There were some systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members. We reviewed five incidents and found that these had been reviewed, discussed and as a result action taken in the form of a change in processes. For example: action had been taken to cease the prescribing of a medicine following two reported incidents.

We saw evidence that learning from incidents was shared with staff via regular meetings and email updates.

Medicines and safety alerts were received by the Superintendent Pharmacist. These were then forwarded to the registered manager and clinical lead, who then disseminated the information to the clinician team. The registered manager and clinical lead were also responsible for checking new updates on the NICE (The National Institute of Health and Care Excellence) guidelines' website and the eBNF (British National Formulary) website on guidance relevant to the organisation each month.

Requires Improvement

Are services effective?

At our previous inspection in May 2019, we found the service was meeting the requirements of the regulations in providing effective services. However, at this inspection we found concerns regarding the monitoring of care.

We rated effective as Requires improvement because:

Assessment and treatment

We reviewed six anonymised medical records which were complete records. We saw that notes were recorded, and the GPs working for the provider had access to all previous notes. However, we saw examples where patient records lacked adequate documentation to support prescribing. Some records lacked a detailed assessment of the patient's presenting symptoms for example, when prescribing antibiotics. We were told that each clinician was required to complete 25 prescriptions per hour. However, we found in some cases, prescriptions were generated in under 30 seconds and in some instances in 15 seconds. Resulting in instances where prescribing was not in line with the services policy.

Patients completed an online form and described details requested which included their past medical history. There were different templates to complete for each condition. The forms included the reasons for the consultation and the outcome to be manually recorded, along with any notes about past medical history and diagnosis. If the provider could not deal with the patient's request, this was explained to the patient and a record kept of the decision.

The service monitored consultations and carried out consultation and prescribing audits to improve patient outcomes. The policy was to audit 1% of the prescriptions issued. The service monitored prescribing decisions and carried out clinical notes audits to improve patient outcomes; this

was done by the clinical lead reviewing records of 1% of each doctor's prescribing decisions per month. The outcomes of these reviews were fed back to individual doctors and used to identify trends which required more systemic intervention. However, these audits did not always identify areas for improvement.

Quality improvement

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

- The service used information about patients' outcomes to make improvements.
- The service took part in quality improvement activity, for example audits, reviews of consultations and prescribing trends. However, these audits did not always identify areas for improvement.
- Other audits completed that resulted in improvements included those relating to complaints and patient feedback.

Staff training

All staff completed induction training which included training on using the patient records system, familiarisation with the service's policies and processes, and shadowing established members of staff. Staff also completed other training on a regular basis including child and adult safeguarding, information governance, Mental Capacity Act and fire safety. The service manager had a training matrix which identified when training was due. The clinicians registered with the service received specific induction training prior to issuing prescriptions. An induction log was held in each staff file and signed off when completed. The clinicians told us they received excellent support if there were any technical issues or clinical queries and could access policies. When updates were made to the IT systems, the doctors received further online training. All staff received regular performance reviews.

Requires Improvement

Are services effective?

Coordinating patient care and information sharing

Before providing treatment, the policy was to ensure there was adequate knowledge of the patient's health, any relevant test results and their medicines history. We saw examples of patients being signposted to more suitable sources of treatment where this information was not available to ensure safe care and treatment. However, the process relied on the patient providing that information with no further systems in place to verify this with the patients' own GP.

All patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service. The service used a General Practitioner (GP) notification system, which automatically generated a letter with details of the consultation and of any prescriptions (if medicines were prescribed by the service). This gave the patient the option to download the letter and share it with their GP themselves or for the service to send directly.

The provider had identified medicines that were not suitable for prescribing if the patient did not give their consent to share information with their GP, or they were not registered with a GP. For example, medicines liable to abuse or misuse, and those for the treatment of long-term conditions such as asthma. Where patients agreed to share their information, we saw evidence of letters sent to their registered GP in line with GMC guidance.

Supporting patients to live healthier lives

The service identified patients who may need extra support and had a range of information available on the website (or links to NHS websites or blogs). For example, in consultation records, we found patients were given advice on healthy living as appropriate. However, we found that in some instances patients were not sent vital information with their medicines. The information provided in the safety netting email was missing vital information on safety netting such as depression/suicide risk associated with one medicine prescribed by the service for smoking cessation which can also be used to treat depression. Following our inspection, the provider wrote to us stating they had taken action to correct this.

Good

Are services caring?

We rated caring as Good because:

Compassion, dignity and respect

We were told that the clinicians undertook telephone consultations in a private room and were not to be disturbed at any time during their working time. The provider carried out random spot checks to ensure the clinicians were complying with the expected service standards and communicating appropriately with patients. Feedback arising from these spot checks was relayed to the clinician. Any areas for concern were followed up and the clinician was again reviewed to monitor improvement.

We did not speak to patients directly on the day of the inspection. However, we reviewed patient feedback left on the providers website. Patient feedback was collected and published through a third party (Trustpilot). Feedback was regularly reviewed, discussed at monthly meetings and used to improve the service.

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. Patients had access to information about the clinicians working for the service.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

Responding to and meeting patients' needs

Consultations were provided seven days a week, between 8:30am and 5:30pm, but access via the website to request a consultation was all day every day. This service was not an emergency service.

The digital application only allowed people to contact the service within the United Kingdom. Any prescriptions issued were delivered within the UK from the providers pharmacy. Patients who requested an online consultation with a clinician were contacted at an allotted time. The provider made it clear to patients what the limitations of the service were.

Tackling inequity and promoting equality

The provider offered consultations to anyone who requested and paid the appropriate fee and did not discriminate against any client group. Patients could access a brief description of the clinicians available through their website.

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 had been developed and introduced for use. We reviewed the complaint system and noted that comments and complaints made to the service were recorded. We reviewed ten complaints out of fifteen received in the past 12 months.

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.

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. This information was provided in an easy to understand about the various conditions and treatment options.

Patients provided consent to treatment when they completed the medical questionnaire. Patients had access to clinicians via the customer service staff who could relay any further queries to the clinicians.

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 was known in advance and paid for before the consultation appointment commenced. The costs of any resulting prescription were paid beforehand.

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. Where a patient's mental capacity to consent to care or treatment was unclear the clinician assessed the patient's capacity and, recorded the outcome of the assessment. The process for seeking consent was monitored through audits of patient records.

Requires Improvement

Are services well-led?

At our previous inspection in May 2019, we found the service was meeting the requirements of the regulations in providing well-led services. At this inspection we found some concerns relating to the clinical leadership of the service and we have rated well-led as requires improvement.

We rated well-led as Requires improvement because:

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 and the mission was to "make healthcare accessible from every home around the world".

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, we found concerns with prescribing and medicines safety. There was evidence of continued issuing of prescriptions for some patients with chronic conditions without assurance that these patients had received adequate monitoring from their own GPs. There were also instances where antibiotics had been prescribed despite a lack of sufficient history. The leaders were not aware of these gaps within their systems and had not undertaken a robust risk assessment to minimise risk for patients whose health required monitoring prior to receiving repeat medicines.

The service undertook monthly audits for the clinical staff. Feedback was provided and used for staff development. However, these audits did not always identify areas for improvement. At the time of our inspection, the provider was unable to demonstrate that formal risk assessments had been undertaken for all other medicines that posed similar risks. However, following inspection the provider told us they had risk assessed the medicines we had identified as concerning during our inspection and had temporarily ceased prescribing these medicines. However ,the provider has not provided us with any further risk assessments to evidence this.

Leadership, values and culture

The Clinical Director had responsibility for any medical issues arising. They attended the service most days with other clinical cover during their absence. There were systems in place to address any absence of this clinician.

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

Safety and Security of Patient Information

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

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

Seeking and acting on feedback from patients and staff

Requires Improvement

Are services well-led?

Patients could rate the service they received via trust pilot. This was constantly monitored and if it fell below the provider's standards, this would trigger a review of the consultation to address any shortfalls. In addition, patients were emailed or telephoned at the end of each consultation with a link to a survey they could complete or could also post any comments or suggestions online. Patient feedback was published on the service's website.

There was evidence that the clinicians could provide feedback about the quality of the operating systems 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 whistle blower is someone who can raise concerns about practice or staff within the organisation.) The Clinical Director was the named person for dealing with any issues raised under whistleblowing.

Continuous Improvement

The leadership team told us they 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.

We saw from minutes of staff meetings where previous interactions and consultations were discussed. Staff told us that the team meetings were the place where they could raise concerns and discuss areas of improvement. Since our last inspection the service had:

Recruited a permanent clinical lead who was supported by an independent medical advisor, lead prescribing doctor and the wider clinical team. The service had moved the dispensing pharmacy on site with a new team. Further improvements had been made to the internal IT systems and data security systems used at the service.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users How the regulation was not being met: The provider did not have systems that ensured prescribing was safe; 1)The prescribing system in place only required the patient to confirm that they had adequate checks. This posed a risk as some patients could provide inaccurate information and there were no systems to verify this. 2) Some patients on medicines that required pre checks continued to receive prescriptions without the provider receiving reassurances from the patients own GP that it was safe to continue to prescribe.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: 1)The provider did not demonstrate sufficient leadership on developing and maintain systems that facilitated safe issuing of medicines. 2)Audits carried out by the provider did not always identify improvements. This was in breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.