Online Clinic (UK) Limited

Online Clinic (UK) Limited - Taybridge Road

Inspection report

39 Taybridge Road
London
SW11 5PR
Tel: 0207 419 5064
Website: www.theonlineclinic.co.uk and www.privatedoctordirect.co.uk

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Overall summary

Letter from the Chief Inspector of General Practice

This inspection was an announced focused inspection undertaken on 21 April 2017, which followed an announced comprehensive inspection at Online Clinic (UK) Limited on 21 March 2017. In March, we found the service was not providing safe, effective or well-led services in accordance with the relevant regulations. However, we found they were providing caring and responsive services in accordance with the relevant regulations.

Following the 21 March 2017 inspection, we took urgent action to safeguard patients and suspended the provider's registration, which took effect from 22 March 2017. This suspension will remain in force until it expires or is removed by the Care Quality Commission. The full comprehensive report on the March 2017 inspection can be found by selecting the 'all reports' link for Online Clinic (UK) Limited on our website at www.cqc.org.uk.

Our key findings across the areas we inspected were as follows:

- The provider showed us evidence of clinical input in to decision making in the form of minuted meetings and emails. However, there were still recommendations made by the clinical lead that had not yet been implemented.
- Some protocols for prescribing for specific areas, such as asthma and emergency contraception, had been completed. However, their creation was not based on risk, was limited in number and did not reference best practice guidelines.
- Limitations to the number of prescriptions that could be issued to one patient had been implemented if a patient did not consent to their GP being informed. However, it would still be possible to receive a single prescription for opioid medicines or asthma medicines on a one off basis without the person's GP being informed.
- The provider had not reviewed the systems in place for medicines prescribed 'off-label'. Information on how to take these medicines was only given online and not included with the medicine, which may have led to inappropriate use.
- We were assured there was a system in place, to aid identification of patients, ready to be implemented once the suspension was lifted on the provider's registration.

Summary of findings

- We saw examples of medicines' alerts, which had been actioned correctly by the registered manager; however, there was no system or process in place to set out roles and responsibilities for disseminating and acting on clinical or prescribing alerts.
- Staff had undergone training the provider deemed mandatory and all files had been updated to reflect the level of training that had completed.
- The provider had ceased treating patients with conditions we highlighted as being potentially unsafe to provide care for in an online environment following our initial inspection, of 21 March 2017.

This inspection of 21 April 2017 found the provider had not yet made adequate improvements and the suspension remains in place.

Professor Steve Field CBE FRCP FFPH FRCGPChief 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 this service was not operating in accordance with the relevant regulations.

- The provider had completed protocols for prescribing in four specific areas; these were asthma, emergency hormonal contraception, pain management and sleep disorders. However, there was no evidence to show why these were prioritised over others and no formal scheduling of further protocols based on risk.
- The provider had not reviewed the systems in place for medicines prescribed 'off-label'.Information on how to take the medicine was only given online and not included with the medicine, which may have led to inappropriate use.
- Limitations to the number of prescriptions that could be issued to individual patients had been placed on patients who had not consented to their GP being informed of treatment. However, we found patients were still able to receive a prescription for opioid-based medicines or asthma inhalers without their GP being made aware.

Are services well-led?

We found this service was not operating in accordance with the relevant regulations.

- There was evidence of clinical input into the decision making and implementation of systems and processes. However, this was limited in capacity and we found some clinical recommendations yet to be applied in practice.
- The provider had implemented a complaints system and made the complaints section on the website clearer to find.
- A full business continuity plan had been developed and partially implemented during the suspension.
- A review of policies and procedures had been undertaken and we saw evidence of these being shared with staff.

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Detailed findings

Background to this inspection

Online Clinic (UK) Limited was registered with the Care Quality Commission on 1 October 2010. The service offers online consultations to patients, through online forms and text based messaging, for a condition selected by the patient themselves. A doctor will then review the request, may ask for further information and then, if appropriate, provide a private prescription to be dispensed by a third party pharmacy. The services are delivered by the provider via two websites; www.theonlineclinic.co.uk and www.privatedoctordirect.com.

At the time of our inspection there were four clinicians working for the service, all of these clinicians were UK based GMC registered doctors. An additional clinical lead was also in place and working with the registered manager.

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.

During our inspection, we spoke with the registered manager, office based staff, and a clinician who worked remotely as the clinical lead. We looked at policies and protocols, medical questionnaires, other documentation and anonymised patient records.

Our inspection team was led by a CQC inspector, and included a CQC Pharmacist Specialist, a GP specialist adviser, and a second CQC clinician.

Are services safe?

Our findings

At our previous inspection on 21 March 2017, we found the provider was not providing safe services in accordance with the relevant regulations. Adequate systems were not in place to ensure the safety of patients when prescribed 'off-label' medicines. There was no system in place to ensure safety or medicines alerts were received, understood or actioned by all relevant staff and there was no oversight of prescribing through formal protocols.

At the follow up inspection on 21 April 2017, we specifically looked at the areas which led to the suspension of the provider's registration and whether the provider had implemented changes to address these serious concerns.

We found this service was not operating in accordance with the relevant regulations.

Overview of safety systems and processes

- The provider had developed protocols for specific disease areas; we were shown four completed ones covering asthma, emergency hormonal contraception, pain management and sleep disorders. However:
- On reviewing these protocols we found they were not always based on the latest best practice guidelines and did not sufficiently mitigate the risks of poor prescribing as highlighted at our inspection on March 2017. For example, if clinicians continued to use the protocol for emergency contraception, that we were shown, it could have potentially resulted in an unintended pregnancy.
- There was no evidence to show why these disease areas had been prioritised over others, and no formal scheduling of updating or reviewing further protocols based on risk.
- During the initial inspection on 21 March 2017, we found that medicines used 'off-label' were dispatched with the standard manufacturer's patient information leaflet. If a medicine is used in a way, which is different from that described in its licence, this is called 'off-label' use. This is higher risk because less information is available to show the benefits of the medicine for an unlicensed condition, and less is known about the potential risks.

  The provider had ceased treating patients with conditions we highlighted as being potentially unsafe to provide care for in an online environment following our initial inspection, of 21 March 2017.

There had been some changes made following the March 2017 inspection, which had improved patient safety. These included:

- Patients requesting opioid medicines, irrespective of type or brand name, were limited to one prescription only before the patient's registered GP had to be informed and further prescriptions would be issued.
- The number of prescriptions for inhalers, used in the treatment of asthma, had been restricted to a single prescription before the patient had to consent to their GP being informed. The provider would then communicate with the patient's GP to ensure they were aware of any further prescriptions. The number of inhalers prescribed had also been restricted to two in a 60-day period.

However, in both these cases, this still allowed medicines to be prescribed without communicating with a registered GP.

- We saw examples of medicines recalls, which had been actioned correctly by the registered manager; however, there was no system or process in place to set out roles and responsibilities for disseminating and acting on clinical or prescribing alerts.
- To improve patient safety the provider had also ceased in providing services to patients with diverticulitis, incontinence or men with urinary tract infections. This decision had been made as it was highlighted in our previous inspection that it was potentially unsafe to provide care for these conditions in an online environment.
- During the inspection, we saw evidence to show a contract to provide identity verification for all patients had been arranged and would be implemented once the provider could resume regulated activities.
- Where necessary, staff, including those at the office, had undergone safeguarding training following a review of their roles. GPs' personnel files had been updated to reflect the training they had previously undertaken. Any further training the provider deemed mandatory had been booked: for example, an online mental capacity act course had been arranged for all staff.

Are services well-led?

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

Our findings

At our previous inspection on 21 March 2017, we found the provider was not providing well-led services in accordance with the relevant regulations; we were not assured of sufficient clinical leadership.

We did not find the leadership at the service had taken all the required actions to address our concerns, when we undertook a follow up inspection on 21 April 2017.

We found this service was not operating in accordance with the relevant regulations.

Leadership, and culture

- During the inspection, we saw some evidence of clinical leadership through minuted meetings and historic email conversations, which had been taken place between the registered manager and the clinicians.
- There was a clinical lead in post. They worked seven hours per week for the provider in this role. We were informed that once the suspension was lifted this GP would perform both their leadership role and prescribe for the service, which would reduce time for leadership and improvement activity.
- We also found evidence that recommendations made by the clinical lead had not yet been implemented in practice. For example, a review of risks to patients stipulated advice-requiring patients answer three standardised questions as recommended by the Royal College of Physicians. This had not been updated in the patient questionnaire relating to asthma.
- The provider had implemented a complaints system and made the complaints section on the website clearer to navigate.
- A full business continuity plan had been developed and partially implemented during the suspension.
- A review of policies and procedures had been undertaken and we saw evidence of these being shared with staff.
- We were told during this inspection that an informal risk assessment had been completed to prioritise service review during the suspension of registration since 22 March 2017. However, we were not shown evidence to substantiate this. We found evidence the provider had not acted to assess and mitigate risks identified during the previous inspection in March 2017. For example, medicines identified in the pain management protocol as being at high risk of misuse had not been reviewed.