Frosts Pharmacy Ltd

Frosts Pharmacy Ltd

Inspection report

Hardwick Shopping Centre
Ferriston
Banbury
Oxfordshire
OX16 1XE
Tel: 01295 262925
Website: www.oxfordonlinepharmacy.co.uk

Date of inspection visit: 24 January 2017
Date of publication: 06/04/2017

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Frosts Pharmacy Ltd on 24 January 2017.

Frosts Pharmacy Ltd 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 was not providing safe, effective and 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.

Our key findings were:

- Patients could access a brief description of the GP available. At the time of our inspection, patients could only access a female GP for the online consultation. A hospital-based general physician who was not a GP, was contracted by the service but was not prescribing for patients.
- Prescribing was monitored to prevent any misuse of the service by patients and to ensure GPs were prescribing appropriately. However, when prescribing was not appropriate there was no evidence that actions were taken to prevent re-occurrence or that learning was disseminated.
- There were no systems in place to mitigate safety risks including analysing and learning from significant events.
- There were no systems in place to ensure that emergency services could be directed to the patient in the event of a medical emergency during consultation.
- There were not appropriate recruitment checks in place for any staff.
- An induction programme was in place for all staff and clinicians contracted by the service had received specific induction. The GP told us they had access to all policies; however some staff were not sure about whether they could access policies on the provider's system.
- Staff had not received training in all areas needed such as Mental Capacity Act 2005, health and safety and fire training.
- Patients were not always treated in line with best practice guidance.
- Medical records were maintained; however recording was not always adequate.
- There was a basic system in place for checking patient's identification; however, these checks did not ensure the provider could confirm who the patient was.
- There were limited clinical governance systems and processes in place to ensure the quality of service provision.

Summary of findings

- The service encouraged and acted on feedback from both patients and staff.
- The provider was aware of and complied with the requirements of the Duty of Candour.
- There was a clear business strategy and plans in place.
- Systems were in place to protect personal information about patients. Both the company and the GP were registered with the Information Commissioner's Office.
- 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.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints. However, learning from those complaints were not always shared with staff.

The areas where the provider must make improvements are:

- Ensure there is a system to record, assess and manage significant events/incidents.
- Ensure prescribing decisions are documented and made appropriately, based on a thorough medical history and made in line with evidence based, risk assessed national guidance and best practice.
- Ensure systems are in place to confirm a patient's identity and that the systems are consistently applied.
- Ensure systems are in place to manage and treat medical conditions appropriately.
- Ensure systems are in place to assist patients in the event of a medical emergency during consultation.
- Ensure consent to care and treatment is sought in line with legislation and guidance and recorded.
- Ensure all staff receive training relating to the Mental Capacity Act 2005, health and safety and fire training.
- Ensure recruitment checks are appropriately carried out and recorded.
- Ensure systems and processes are in place to ensure the effective governance of the service.

The areas where the provider should make improvements are:

- Ensure there are regular team meetings and clinical meetings and minutes from those meetings are appropriately documented.
- Ensure learning from complaints and feedback are shared with all staff.
- Improve accessibility to the service for patients who may find it difficult to use the telephone and for those where English is not their first language.

We are now taking further action against the provider Frosts Pharmacy Ltd in line with our enforcement policy. Since the inspection, the provider has submitted an action plan in response to the issues found on inspection. We will check the effectiveness of these actions when we re-inspect.

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

- Prescribing of medicines was monitored; however, where the prescribing had been found to be inappropriate, there was no evidence that actions were taken to prevent re-occurrence or that learning was disseminated.
- There were no systems in place to mitigate safety risks including analysing and learning from significant events.
- Appropriate recruitment checks had not been fully carried out for any staff.
- Staff working in the headquarters had had only limited fire and health and safety training.
- The provider's current system for checking the identification of a patient when they registered for the service was limited to a basic credit card check.
- There were no systems in place to ensure emergency services were directed to the patient in the event of a medical emergency occurring during a consultation.
- There were systems in place to protect all patient information and ensure records were stored securely. Both the service and the GPs were registered with the Information Commissioner's Office.
- The service had a business contingency plan.
- The provider was aware of and complied with the requirements of the Duty of Candour and encouraged a culture of openness and honesty.
- There was one GP to meet the current demand of the service. The provider was in the process of reviewing the staffing level.
- All staff had received safeguarding training appropriate for their role. All staff had access to local authority information if safeguarding referrals were necessary. There was a safeguarding lead and all staff we spoke with were aware of who the safeguarding lead was.

Are services effective?

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

- Consent to care and treatment was not sought in line with the Mental Capacity Act 2005 and staff had not received Mental Capacity Act training.
- We were told that the 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) best practice guidelines. patients were not always treated in line with best practice guidance.
- The service had arrangements in place to coordinate care and share information appropriately for example, when patients were referred to other services. Consent to share information with the patient's own GP was sought on the consultation forms.
- Staff gave us different explanations as to how tests results were managed. The provider told us that test results would be seen and actioned by the GP. Yet non-clinical staff told us that when test results were received, they would contact the patient about the results and advise them on a suitable course of treatment without speaking to a clinician. The provider updated the standard operating procedure after our inspection to ensure certain abnormal results were forwarded to the GP to action.
- 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.

Summary of findings

- There were induction, monitoring and appraisal arrangements in place to ensure staff had the skills, knowledge and competence to deliver effective care and treatment. However, there were shortfalls in staff training. For example, staff had not received training relating to the Mental Capacity Act 2005, health and safety and fire training.

Are services caring?

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

- Systems were in place to ensure that all patient information was stored and kept confidential.
- The provider shared examples of how they delivered medicines to patients when these were required urgently.
- We did not speak to patients directly on the days of the inspection. We reviewed information on an online review website. We reviewed 40 online reviews from patients which were all positive about the service. Patients commented on the excellent, fast and professional service they received from the service.

Are services responsive to people's needs?

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

- There was information available to patients to demonstrate how the service operated. Patients could access the service either by e-mail or by phone.
- Patients could access the service from 9am to 5.30pm, Monday to Friday and 9am to 1pm on Saturdays.
- The service gathered feedback from patients though 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 analysed trends and identified actions to improve the service. However, there was no evidence that learning points had been cascaded to staff.
- The provider had sent out surveys to patients between February and March 2016, and results from these surveys had been analysed and learning points identified. However, there was no evidence that these learning points had been cascaded to staff.
- Patients could access a brief description of the available GP on the provider's website.
- Staff told us that translation services were not available for patients who did not have English as a first language. The provider's website only had information and application forms in English.
- There was a complaints policy which provided staff with information about handling formal and informal complaints from patients.

Are services well-led?

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

- The governance framework of the service had not ensured systems and processes were in place and embedded in the service to keep patients safe. For example, there were no systems and processes in place to identify and manage significant events. The service identified in their clinical meeting in January 2017 that they needed a process however; this had not been implemented yet.
- There were a number of policies and standard operating procedures available; however, two members of staff were unaware that these could be accessed on the cloud based system. Hard copies of policies and standard operating procedures were available on site.
- The provider held between two and three clinical meetings a year and we saw minutes of these meetings. However, those minutes were not always clear about the discussions held.

Summary of findings

- There was a management structure in place, and the staff with whom we spoke understood their responsibilities. Staff were aware of the organisational ethos and philosophy; 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.
- Office based staff had received annual appraisals.
- The provider had engaged two external agencies to develop their online service and manage health and safety and human resources issues.
- The provider had plans to recruit a quality assurance pharmacist to undertake regular audits and identify areas for improvement in the service.

Frosts Pharmacy Ltd

Detailed findings

Background to this inspection

Background

Frosts Pharmacy Ltd is based in Banbury in Oxfordshire. Frosts Pharmacy Ltd set up an online service in October 2012 which includes consultation with a GP. The provider moved the online part of the service to an industrial unit in October 2016. We did not inspect the provider's affiliated pharmacy. We inspected the online service which is also known as Oxford Online Pharmacy at the following address:

Unit 7, Apollo Office Park, Ironstone lane, Wroxton, Banbury, OX15 6AY.

Frosts Pharmacy Ltd provides an online primary care consultation service and medicines ordering service. Patients register for the service on the provider's website, select the medicines they require, complete an online consultation form which is reviewed by a GP, and if approved, the affiliated pharmacy (which we do not regulate) sends the medicines to the patient by secure post.

The service employs staff who work on site including a pharmacy manager, pharmacy and dispensing staff and administrative staff. At the time of the inspection, the service had approximately 41,200 patients registered. However, although all those patients registered with the service, not all of them may have been prescribed medicines. The provider estimated that approximately 10,000 of those patients may have not completed their order or had their prescriptions declined.

The service can be accessed through their website, www.oxfordonlinepharmacy.co.uk where patients can place orders for medicines seven days a week. 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 5.30pm, Monday to Friday and 9am to 1pm on Saturdays. This is not an emergency service. Subscribers to the service pay for their medicines when making their on-line application. Once approved by the prescriber, medicines are dispensed, packed and posted; they are delivered by a third party courier service.

Frosts Pharmacy Ltd was registered with Care Quality Commission (CQC) on 23 January 2015 and have a registered manager in place. A registered manager is a person who is registered with the CQC 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. At the time of our inspection, the provider was in the process of updating their registration to reflect their new address.

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

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew.

During our visits we:

- Spoke with a range of staff including the Managing Director, the pharmacist manager, a pharmacist, a pharmacist technician, two doctors and non-clinical staff.
- Reviewed organisational documents.
- 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?

Detailed findings

- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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.

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

We found that this service was not providing safe services in accordance with the relevant regulations.

Safety and Security of Patient Information

Frosts Pharmacy Ltd provides an online primary care consultation service and medicines ordering service. Patients register for the service on the provider's website. All patients' information was stored on the provider's computer system.

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

The provider's current system for checking the identification of a patient when they registered for the service was inadequate. The system did not confirm if the patients were who they said they were, or identify if they were male, female or under the age of 18. The service was not intended to treat children.

Prescribing safety

Medicines prescribed to patients were monitored by the provider to ensure prescribing was appropriate. However, where shortfalls were identified, learning was not always shared and actions implemented to prevent the same thing happening again. We also saw evidence of a clinical interventions log, with examples of medicines orders that had been cancelled due to a clinical intervention, mainly by the pharmacist. For example, a medicine for erectile dysfunction was ordered for a urinary condition. Any issues that arose between the prescriber and the affiliated pharmacy or the prescriber and the patients requesting prescriptions were dealt with as they arose.

If a medicine was deemed necessary 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.

Once the patient selected the medicine and dosage and this was reviewed by the prescriber, 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 noted that the provider prescribed off label medicines, for example a medicine for use in hair loss, at a strength which is not licensed for that use. Because the medicine was being used outside of its licensed indication, the leaflet supplied by the manufacturer did not include information which was relevant to those patients. We found that the pharmacist did provide additional information as part of the online prescribing service to advise the patient about when and how to take these medicines. However, we did not see evidence of consent by the patient to acknowledge and accept that they were receiving a medicine for use outside of its licence. This posed a risk to the patients and was not in accordance with General Medical Council guidance.

We looked at patient consultation records and were concerned at some of the prescribing decisions. For example, one patient was prescribed more than the recommended asthma reliever inhalers over a six month period. There was a risk this person may suffer a life-threatening exacerbation of asthma because they were not being appropriately reviewed in response to their high usage of reliever inhaler. For another patient, we found that six courses of an anti-viral had been prescribed over a period of two years and four months. This was inappropriate as the patient should have been referred for further investigation; prescribing was not in accordance with best clinical practice and national guidance.

Prescriptions could be dispensed and delivered direct to the patient. Dispensed medicines were packed in an unbranded packaging and delivered by a third party courier service.

Management and learning from safety incidents and alerts

We asked the provider what systems were in place to identify and analyse any incidents, near misses and clinical errors. We were showed a clinical intervention log, which was a log where prescriptions or orders had been cancelled by the pharmacist because the medicine requested by the patient was not appropriate. However, there was no evidence of meeting minutes where learning from these incidents were shared with all staff.

Are services safe?

We saw evidence from one incident 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 saw a system of recording and monitoring safety alerts, such as those provided by the Medicines and Healthcare products Regulatory Agency (MHRA). These were done by pharmacy staff and we saw evidence that they were distributed to clinical staff within the organisation so that they had access to updated prescribing information.

Safeguarding

Staff employed at the service had received training in safeguarding and whistleblowing and knew the signs of abuse and to whom to report them. The GP and the doctor had received level three child safeguarding training and adult safeguarding training. Doctors contracted by the service kept records of their own training; however, we did not see evidence that the service held copies of these on file. All staff had access to safeguarding policies, and could access information about to whom to report a safeguarding concern.

However, staff had not received training about the Mental Capacity Act 2005. The provider sought consent from the patient to share information with their own GP on their online forms; however, we did not see evidence that consent for care and treatment was sought at each stage of consultation. There was no evidence consent was sought from patients who made a request for medicines and consultation through a family member.

Staffing and Recruitment

There were enough staff to meet the demand of the service and there were two doctors (a GP and a hospital-based general physician who was not a GP) available from Monday to Friday during business hours. At the time of the inspection only one of those doctors, who was a GP, was prescribing for patients using the service. There was a support team available to the GP during consultations and a separate administration team. The provider recognised that they needed more doctors who were able to prescribe and had arrangements in place to access another doctor should the need arise.

The provider had a selection process in place for the recruitment of all staff. However, we found that the required recruitment checks were not carried out for all staff prior to commencing employment. Potential GP candidates had to be registered with the General Medical Council (GMC) and on the GMC GP register and had their appraisal. The doctor who was not a GP was providing governance assistance to the GP and the service. Those GP candidates that met the specifications of the service then had to provide documents including their medical indemnity insurance, proof of registration with the GMC, proof of their qualifications and certificates for training in safeguarding and the Mental Capacity Act 2005. Doctors contracted by the service kept records of their own training but we did not see evidence that the provider held copies of these on file. We reviewed six recruitment files which showed that the necessary documentation was not available. For example, none of the six staff files we reviewed contained references, two members of staff had not received a Disclosure and Barring Service check and there were no records of employment history for five members of staff.

Monitoring health & safety and responding to risks

The provider informed patients what the limitations of the service were on their website. The service was not intended for use as an emergency service. However, there were no processes in place to manage any emerging medical emergencies during a consultation.

The supporting team carried out a variety of checks either daily or weekly such as checking for queries from patients and that orders have been processed. Clinical meetings were held between two and three times a year. However, minutes from these meetings did not show where learning from incidents had been shared with all staff. The provider told us at the inspection that they had now started to schedule weekly clinical meetings where learning from incidents, feedback and significant events can be shared and disseminated to staff.

The provider is currently providing regulated activities from a purpose built industrial unit which accommodates the management and administration staff. Patients were not treated on the premises and the GP carried out the online consultations from their home. The provider had recently appointed an external contractor to manage health and safety and human resources issues. Administration staff had not received training in health and safety including fire safety. We were told that they had plans to complete this by the end of March 2017.

Are services effective?

(for example, treatment is effective)

Our findings

We found that this service was not providing effective services 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 the costs of a consultation and of medicines available, and a set of frequently asked questions for further supporting information. The website had a set of terms and conditions and details on how the patient could contact them with any enquiries. Information about the cost of the consultation and prescription was known in advance and paid for before the online form was reviewed.

The provider sought consent to sharing information with the patient's GP or other relevant services. However, there was no evidence that information was consistently shared with the GP.

The provider did not seek patients' consent to care and treatment in line with legislation and guidance for patients who made a request through a family member.

We noted that the service processed anti-malarial medicines for parents if they requested this for their children. There was no system in place to verify parental responsibility when processing those requests.

Assessment and treatment

We reviewed 16 examples of medical records and were concerned at some of the prescribing decisions. For example, we saw evidence where patients with asthma did not have their condition managed and treated appropriately.

We were told that the GP reviewed the online questionnaires filled in by patients and if they were unable to reach a decision as to the appropriateness of prescribing the medicine, there was a system in place where the GP could contact the patient for further information.

Patients completed an online form which included their past medical history. There was a set template to complete for the consultation that included the reasons for the consultation and the outcome to be manually recorded, along with any notes about past medical history and diagnosis. From the medical records we reviewed we saw that notes had not been adequately completed. For example, a patient had been prescribed medicine for erectile dysfunction; however, there was a lack of information to show that this was appropriate given the patient had a pre-existing heart condition. The GP had access to all previous notes that the provider kept on record.

The GP providing the service was 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; however, they failed to assess and minimise the risks for patients. If a patient needed further examination, for example if the patient required a blood test, they were directed to an appropriate agency. 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 provider also told us that results from blood sample tests would be seen and actioned by the GP who would make contact with the patient about appropriate treatment. However non-clinical staff told us that when test results were received, they would contact the patient about the results and advise them on a suitable course of treatment without consulting a clinician. The provider updated their standard operating procedure since our inspection to ensure certain abnormal results were forwarded to the GP to action.

The service monitored consultations and carried out consultation and prescribing audits. Although the service has gathered data to identify improvements, there was no evidence of quality improvement. The provider had undertaken two clinical audits; however, none of these were completed audits where the improvements identified were implemented and monitored. For example, an audit into prescribing for patients with asthma identified a range of improvements including adding an additional field to the online asthma's questionnaire where patients could tell the online GP when they had their last review with their own GP or Nurse and indicate whether they have a personalised plan in place. The audit also identified that the prescribing GP should ask the patient further questions if they indicated that they used more than three doses of their inhalers a week and recommend a review with the patient's own GP or Nurse to consider the use of preventer inhaler. Other improvement identified was for the provider

Are services effective?

(for example, treatment is effective)

to send out health information leaflet on smoking, weight management and asthma management. However, these actions had not been implemented yet as the audit was undertaken in January 2017.

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 NHS GP. However we did not see evidence that consultation notes were consistently shared with the patient's GP.

Where the patient requested to have a blood test, a blood testing kit was sent to the patient by post with instructions on how to provide a sample. The blood testing kit included a pre-paid envelope to be sent to a laboratory. Results from the test were then sent back to the provider who shared this information with the patient either via e-mail or over the phone. Due to the lack of effective identity check, we were not assured the result related to the patient who had the test carried out.

Supporting patients to live healthier lives

The service identified patients who may be in need of extra support and had a range of information available on the website. For example: tips to beat a cold, exercising in winter and smoking cessation.

Staff training

All staff had to complete induction training which consisted of health and safety, fire training, safeguarding and first aid. We noted that none of the staff at the headquarters had received fire, health and safety and Mental Capacity Act 2005 training. There were no records of when three members of staff had completed first aid training. The GP kept a record of their own training and appraisal. Administration staff received annual performance reviews.

Are services caring?

Our findings

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

Compassion, dignity and respect

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

The provider engaged with an online review website on which they are rated by customers. We reviewed 40 online reviews from patients which were all positive about the service. Patients commented on the excellent, fast and professional service they received from the service. They had an overall rating of 9.4 out of 10. The provider shared examples of how they personally delivered medicines to patients when these were required urgently.

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. Information on the provider's website informed patients about each medicine that was available, the cost of the medicine, how to use a medicine and the potential side effects.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting patients' needs

There was information available to patients to demonstrate how the service operated. Patients could access the service from 9am to 5.30pm, Monday to Friday and 9am to 1pm on Saturdays. Help and support from the service could be accessed either by e-mail or by phone.

Patients who had a medical emergency were advised on the provider's website to ask for immediate medical help via 999.

The digital application allowed patients to contact the service from abroad but all GP practitioners and doctors were required to be based within the United Kingdom. Any prescriptions issued were delivered using a third party courier service.

Tackling inequity and promoting equality

The provider offered consultations to anyone who requested and paid the appropriate fee, and did not discriminate against any client group.

Patients could access a brief description of the only GP available. At the time of our inspection, patient could access one female GP. The provider had plans to have more doctors available for the service in the near future.

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

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. The service gathered feedback from patients through an online review website. Where there was negative feedback received we found they had responded to these in a timely way. The provider had analysed trends and identified actions to improve the service. For example, patients did not always know that they can view messages from the provider in the account they created when they registered with the service. The provider was working with an external agency to improve their website generally and part of this would be to inform patients that they can view messages within their account. However, there was no evidence that these learning points had been cascaded 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 care and patient safety at its heart. We reviewed business plans that covered the next two years. The provider was committed to making access to healthcare easier where patients were in control of their own health.

There was a clear staffing 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. Hard copies of policies and standard operating procedures were available in the service. The provider and the GP told us that these were also available on a system which would give all staff, including those working remotely, access to the policies. However, some members of staff were not sure that they could access these on the system.

The supporting team carried out a variety of checks either daily or weekly such as checking for queries from patients and that orders have been processed. Clinical meetings were held between two and three times a year. However, minutes from these meetings were not adequate and did not show where learning from incidents had been shared with all staff. The provider told us that they had now started to schedule weekly clinical meetings where incidents, feedback and significant events can be discussed and learning shared and disseminated to staff.

There were arrangements for identifying and recording risks, issues and implementing mitigating actions. However, there was no evidence that trends had been identified; actions to prevent re-occurrence of incidents; nor was there evidence that learning had been shared with all staff.

From the 16 medical records we reviewed we saw that notes had not always been adequately completed. For example, a patient had been prescribed medicine for erectile dysfunction; however, there was a lack of information to show that this was appropriate given the patient had a pre-existing heart condition. This could place the patient at risk as key information relating to the clinical decision and appropriateness of the medicines was lacking.

Leadership, values and culture

The Managing Director had responsibility for any medical issues arising. He attended the provider's location daily. There were systems in place to address any absence of the Managing Director. The provider realised that the service had grown considerably and had plans for more doctors to be available for patients using the service in the future.

The values of the service were to focus on a traditional family run business values whilst adapting to modern day demands.

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.

Seeking and acting on feedback from patients and staff

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

There was evidence that staff could also feedback about the quality of the operating system and any change requests were discussed.

The provider had a whistleblowing policy in place. A whistleblower is someone who can raise concerns about practice or staff within the organisation. The Managing Director was the named person for dealing with any issues raised under whistleblowing.

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.

Are services well-led?

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

Staff told us that the team meetings were the place where they could raise concerns and discuss areas of improvement. However, as the management team and administration teams worked together at the headquarters there was ongoing discussions at all times about service provision. Minutes from meetings were not thorough enough to demonstrate the discussions held and did not show evidence of learning from incidents, significant events or complaints being cascaded. The Managing Director told us there was a staff group set up on a messaging service where they communicated more regularly.

The provider had engaged two external agencies to develop their online service and manage health and safety and human resources issues. The provider had plans to recruit a quality assurance pharmacist to undertake regular audits and identify areas for improvement in the service.

The provider told us they were planning to introduce a 24 hour helpline where patients could call at any time and speak to someone if they required assistance.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent (1) Care and treatment of service users must only be provided with the consent of the relevant person. **How the regulation was not being met:** • Consent to care and treatment was not sought in line with legislation and guidance and was not recorded. This was in breach of regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** • Systems in place to confirm a patient's identity was not adequate. • Prescribing decisions were not made appropriately, not based on a thorough medical history and not made in line with evidence based; risk assessed national guidance and best practice. • There were no systems in place to assist patients in the rare event of a medical emergency occurring during consultation. • Information was not shared with a patient's primary physician to ensure prescribing was safe or appropriate. • There was no system in place to ensure patients' conditions were being appropriately monitored. • Staff had not received training relating to the Mental Capacity Act 2005, health and safety and fire training. • There was not an effective system to record, assess and manage significant events. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:**

This section is primarily information for the provider

Enforcement actions

- There was no overarching clinical governance system to ensure prescribing was safe and appropriate.
- There was no overarching governance system to ensure that systems and processes were in place and embedded in practice.
- The registered manager had not retained all the information required as stated in Schedule 3 of the Health and social Care Act 2008 (regulated Activities) Regulations 2014 when undertaking recruitment.

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