PostMyMeds

Quality 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.

Contents

Summary of this inspection

Page

Overall summary 1
The five questions we ask and what we found 4
Areas for improvement 7

Detailed findings from this inspection

Our inspection team 8
Background to PostMyMeds 8
Why we carried out this inspection 8
How we carried out this inspection 8
Detailed findings 10
Action we have told the provider to take 20

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at PostMyMeds Limited on 9 May 2017.

The service provides on-line prescribing of medicines for specified treatment areas following the review of an online consultation questionnaire by a GMC registered GP. The service operates from a high street location which is also the location of the organisation's affiliated pharmacy which dispenses the medicines prescribed. The pharmacy is registered and regulated by the General Pharmaceutical Council (GPhC).

Summary of findings

We found this service was providing caring, effective, responsive and well led care in accordance with the relevant regulations. However, improvements were required in relation to providing safe care.

Our key findings were:

- The service had clear systems to keep people safe and safeguarded from abuse.
- There was a system in place to check identity which consisted of a credit card check; a check against the electoral roll, IP address and duplicate orders from the same address.
- There were systems in place to mitigate safety risks including analysing and learning from significant events. The service learned and made improvements when things went wrong. The provider was aware of and complied with the requirements of the Duty of Candour.
- Improvements were made to the quality of care as a result of complaints.
- There were appropriate recruitment checks in place for staff. However, not all staff had undergone a Disclosure and Barring Service (DBS) check and a risk assessment had not been undertaken to identify potential risks this posed to service users. The provider took immediate action to address this and provided evidence of the DBS check application.
- Prescribing was monitored to prevent any misuse of the service by patients and to ensure that prescribing by the GP was appropriate.
- There were systems to ensure staff had the information they needed to deliver safe treatment to patients.
- Patients were treated in line with best practice guidance and safety alerts were acted on appropriately.
- Appropriate medical records were maintained which reflected the condition treated and medicine prescribed.
- The service had a programme of ongoing quality improvement.
- All staff, including the GP, had access to policies and procedures. However, not all policies were fully personalised to reflect the needs of the service and some did not include a date of issue or date for future review.
- The service encouraged the sharing of information about treatment with the patient's own GP.
- Consultation records we viewed showed that patients were treated with compassion, and respect and they were involved in their care and decisions about their treatment.
- Comprehensive, closed-question disease and medicine specific consultation templates were used. However, the language used was sometimes not sufficiently clear for all service users to understand and one did not include the facility for patients to record all relevant information. Some templates did not include all appropriate medicine interactions. However, the provider took immediate action to address these issues.
- There was a clear business strategy and plans in place.
- There were clinical governance systems and processes in place to ensure the quality of service provision.
- The service encouraged and acted on feedback from both patients and staff.
- Systems were in place to protect personal information about patients. The company was registered with the Information Commissioner's Office.
- The service encouraged and acted on feedback from both patients and staff.

We identified regulations that were not being met and the provider must make appropriate improvements (please see the requirement notice at the end of this report).

Care and treatment was not being provided in a safe way for service users.The provider was not doing all that is reasonably practicable to mitigate risks to service users regarding the proper and safe management of medicines.

The provider must ensure that current and future consultation questionnaires are reviewed to ensure that:

- the language used can be understood by all service users.
- they include reference to all relevant medicine interactions.
- they include the facility for patients to enter all relevant information.

The areas where the provider should make improvements are:

- The provider should keep under review the systems they have in place to confirm the identity of patients using the service, so that they can be assured that care and treatment is provided in a safe way.

Summary of findings

- The provider should carry out an assessment of risk to service users to determine if a Disclosure and Barring Service check should be carried out for employed staff.
- The provider should ensure that all policies are personalised to reflect the needs of the service and should include a review date.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

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

- All staff had access to policies and procedures. However, not all policies were fully personalised to reflect the needs of the service and some did not include a date of issue or date for future review.
- The language used in consultation templates was not always clear for all service users to understand and one did not include the facility for patients to record all relevant information. Some templates did not include all appropriate drug interactions.
- All staff had received safeguarding training appropriate for their role. All staff had access to local authority information if safeguarding referrals were necessary.
- Patient identity was checked on registration, at every consultation and when prescriptions were issued.
- There was sufficient GP time to meet the demands of the service and arrangements were in place to cover GP absence.
- There were appropriate recruitment checks in place for staff. However, not all staff had undergone a Disclosure and Barring Service (DBS) check and a risk assessment had not been undertaken to identify potential risks this posed to service users. The provider took immediate action to address this and provided evidence of the DBS check application.
- The service had a business contingency plan.
- Prescribing was monitored to identify risks to patients.
- There were systems in place for identifying, investigating and learning from incidents relating to the safety of patient care. The provider was aware of and complied with the requirements of the Duty of Candour and encouraged a culture of openness and honesty.

Are services effective?

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

- We saw evidence that patients' needs were assessed and care delivered in line with relevant and current evidence based guidance and standards; for example, National Institute for Health and Care Excellence (NICE) evidence based practice.

Summary of findings

- We reviewed a sample of consultation records that demonstrated appropriate record keeping and patient treatment.
- The service had a programme of ongoing quality improvement activity. For example, nine clinical audits had been undertaken in the past 12 months.
- Staff had the skills, knowledge and competence to deliver effective care and treatment.
- The service had arrangements in place to coordinate care and share information appropriately if required. Patients were required to agree that they would inform their own GP of the medicines they were prescribed before they completed a consultation template. Patients were also sent an email following dispatch of their medicines to confirm that the provider would send prescribing information to the patient's GP if the patient requested.
- The service website contained information to help support patients to lead healthier lives, and information on healthy living was provided as appropriate.

Are services caring?

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

- The GP informed us that they undertook all online consultations in a private room, for example in their surgery or own home.
- The provider carried out regular audits to ensure prescribing complied with the expected service standards and communication with patients was appropriate.
- We did not speak to patients directly on the day of the inspection. However, we reviewed patient survey responses over the past 12 months. Patients' responses indicated that they were satisfied with the treatment they received.

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 accessed the service via the provider's website. The online system had a 'live chat' facility. This was in operation from Monday to Friday from 9am to 5pm and Saturday from 9 am to midday. Users of the service could send instant messages to the pharmacists operating the service.

Summary of findings

- Patients could access details of the prescribing GP on the website (this included their name and GMC registration number).
- There was a complaints policy which provided staff with information about handling formal and informal complaints from patients. Information was available on the provider's website informing patients what to do if they wished to make a complaint.
- Consent to care and treatment was sought in line with the provider's policy. The GP and Registered Manager had received training about the Mental Capacity Act.

Are services well-led?

We found that this service was providing well-led care in accordance with the relevant regulations.

- All appropriate policies and procedures were accessible to staff, including those working remotely. However, some of the policies were not personalised to reflect the needs of the service and did not include a date of issue or date for future review.
- There were business plans and an overarching governance framework in place to support clinical governance and risk management.
- There was a management structure in place and all staff understood their responsibilities.
- There was an awareness of the organisational ethos and philosophy, and a supportive and proactive approach to patient safety and quality improvement.
- The service encouraged patient feedback. There was evidence that staff collaborated when developing services and making improvements to the quality of operating systems.
- Systems were in place to ensure that all patient information was stored securely and kept confidential. The service was registered with the Information Commissioner's Office.

Summary of findings

Areas for improvement

Action the service MUST take to improve

The provider must ensure that current and future consultation questionnaires are reviewed to ensure that:

- the language used can be understood by all service users.
- they include reference to all relevant medicine interactions.
- they include the facility for patients to enter all relevant information.

Action the service SHOULD take to improve

- The provider should carry out an assessment of risk to service users to determine if a Disclosure and Barring Service check should be carried out for employed staff.
- The provider should ensure that all policies are personalised to reflect the needs of the service and should include a review date.

PostMyMeds

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector accompanied by a second inspector, a GP Specialist Adviser and a Pharmacist Specialist.

Background to PostMyMeds

Background

PostMyMeds Limited provides on-line prescribing of medicines for specified treatment areas following the review of an online consultation questionnaire by a GMC registered GP. The service operates from a private community pharmacy in a high street location.

The organisation is owned and managed by two directors, both of whom are pharmacists and responsible for undertaking all the operational activities of the service. They currently employ one GP and one IT/Marketing consultant on a contractual basis. They have contingency plans in place to cover the absence of clinical staff. The service issued 3546 prescriptions in the preceding 12 months.

Patients complete an online consultation form for a selected medicine. This is then reviewed by the GP who will issue a private prescription if it is deemed suitable. The prescription is then dispensed from the providers affiliated pharmacy ready for collection or delivery. The service only offers treatment options for conditions that the provider has deemed suitable for diagnosis and management via an online consultation form without the need for a face to face consultation.

Comprehensive information on the treatment area and medicines selected was provided on the website and patients can contact the provider for any additional information or assistance required.

The service operates Monday to Friday from 9am to 5pm and Saturday from 9am to midday. Users of the service could send instant messages to the pharmacists via their online 'live chat' facility during this time.

Prescribed medicines purchased before 4pm on a weekday and before 11am on a Saturday are dispatched the same day. Prescribed medicines purchased after these times were dispatched the following working day. Medicines were only delivered to addresses within the UK only.

The service has been registered with the CQC since February 2016 for the regulated activity of treatment of disease, disorder and injury.

PostMyMeds is also registered and regulated by the General Pharmaceutical Council (GPhC) and the Medicines and Healthcare Regulatory Agency (MHRA) which regulates the pharmacy services provided by the organisation.

One of the directors is the Registered Manager for the service. (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.)

Why we carried out this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory

Detailed findings

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.

How we carried out this inspection

Before visiting, we reviewed a range of information provided by the provider.

During our visit we:

- Spoke with a range of personnel including the Registered Manager and GP.
- Reviewed organisational documents, including minutes of meetings and policies and procedures.
- Reviewed a sample of patient records.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

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

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 care in accordance with the relevant regulations.

Keeping people safe and safeguarded from abuse

The provider did not employ staff on the premises. The Registered Manager was the Safeguarding Lead and had received training in adult safeguarding, including Mental Capacity Act and level 3 training in safeguarding children and knew the signs of abuse and to whom to report them. The GP had also received level 3 child safeguarding training and adult safeguarding training. It was a requirement for the GP recruited by the service to provide safeguarding training certification. There was access to safeguarding policies including information and contact numbers regarding who to report a safeguarding concern to.

The service did not offer treatments to patients under 18 years of age.

Monitoring health & safety and responding to risks

We saw evidence of operating procedures detailing dispensing procedures and identity verification prior to processing orders.

The provider used several checks to try to mitigate the risks involved in ordering medicines online and protect against patients using multiple identities. These included:

- Order history: Users placing an order had to agree to a registered account being made under their details and only one account could be registered per user.
- Credit card check using the SagePay features confirmed that the address and postcode of the card-holder matched the address entered and confirmed their location.
- Online directory checks such as the electoral roll (192.com) to search for any patient requiring an additional identity check.
- IP address check.

The provider was also in process of commissioning the LexisNexis service to carry out identity checks. All actions undertaken were documented against the patient's notes.

Safe management of medicines

The provider had carried out a risk assessment to determine which conditions to treat. The provider's rationale behind the medicines choice was that they were conditions that could be treated via questioning alone and without the need for physical examinations or tests.

At the time of this inspection, there were no unlicensed medicines or controlled drugs prescribed by the service. (Controlled drugs are medicines that are subject to the Misuse of Drugs legislation and subsequent amendments). Patients could only request the medicines listed on the website. There was no facility to prescribe any other medicines.

The provider informed us of medicines they had withdrawn following identification of increased risk following changes in national guidelines. For example, previously the service offered treatment for traveller's diarrhoea and bacterial vaginosis, however, these treatments were no longer available to patients. The decision to remove these treatments was made after considering information regarding appropriate antibiotic stewardship and was discussed and agreed with the lead clinician.

We looked at a variety of patient consultation records and saw examples where the request for the prescription was refused. Reasons for refusal included:

- Too many requests made in a short period of time.
- Medicines for use by a male were requested using the account details belonging to a female.
- Large quantity requests.
- Patient outside of age limit for prescribing a particular medicine.

The provider's headquarters is located within a modern purpose built high street shop. Patients were not treated on the premises although there was a private room available on the premises. The GP carried out the online consultations remotely usually from their surgery or home. The IT/marketing consultant also worked remotely.

A confidentiality policy was in place which required the GP to conduct consultations in a private location to maintain patients confidentiality. The GP we spoke to confirmed that they adhered to this. The GP used their own computer to log into the operating system, which was a secure programme, and had completed a remote working risk assessment to ensure their working environment was secure and maintained confidentiality.

Are services safe?

The service was not intended for use by patients with long-term conditions or as an emergency service. The questionnaire was designed to terminate a consultation if the treatment was inappropriate or if urgent treatment was required.

Staffing and Recruitment

The service was provided by two pharmacists (the provider), a GP and an IT/marketing consultant. There were arrangements in place for a pharmacist independent prescriber to provide temporary cover in the GP's absence if required.

Recruitment checks were carried out for staff prior to commencing employment. The GP also worked as an NHS GP and was registered with the General Medical Council (GMC). Records were kept to confirm medical indemnity insurance cover, proof of registration with the GMC, proof of qualifications and certificates for training in safeguarding and the Mental Capacity Act and evidence of their annual GP appraisal.

We reviewed two recruitment files which showed the necessary documentation was available. However, DBS checks had not been undertaken for the IT/marketing consultant who had access to patient records. A risk assessment had not been undertaken to identify potential risks this posed to service users. The provider took immediate action to address this and provided evidence of the DBS check application for the member of staff. The provider kept records for staff and flagged up when any documentation was due for renewal such as their professional registration and indemnity cover.

Prescribing safety

Service users were required to select a medicine listed under one of the fourteen treatment areas. They were then required to complete a comprehensive closed-question consultation template which took into account the clinical risks posed by the specific medicine to be prescribed.

Medicines were prescribed by a General Medical Council (GMC) registered GP (or pharmacist independent prescriber during periods of absence cover) following completion of the online consultation form by the patient. If a medicine was deemed appropriate following a review of the consultation form, the GP would issue a prescription which would go direct to the PostMyMeds pharmacy service. The GP was only able to prescribe from a set list of medicines for the conditions advertised on the website. There were no controlled drugs on this list.

We found the questionnaires that patients were required to complete took into account clinical risks posed by the various medicines. We had some concerns regarding the medicine interaction list for the emergency contraceptive 'EllaOne' and the provider addressed these concerns on the day of inspection and updated the forms appropriately.

There were also some concerns regarding the prescribing of weight-loss medicines which could be obtained without the patient recording a specific up to date weight. The questionnaire for Xenical (Orlistat), a weight loss treatment, required patients to confirm if their BMI was 30 or above. However, there was no explanation of what BMI means or how to calculate it. (BMI - body mass index - is a value derived from the weight and height of an individual). It also asked the patient to confirm that they had achieved a 5% weight loss. This relied on the patient accurately calculating this information which risked service users making mistakes when calculating results.

The provider took immediate action to address this by altering the questionnaire to require an up to date weight and height measurement each time a prescription was requested. An automatic calculation then ensured that an accurate record of BMI was recorded and the prescriber would calculate the weight loss.

We noted that the language used in some of the questions may not have been understood by all service users. One of the questionnaires asked whether the patient was taking any 'MAOIs'. It was felt that service users may not understand that the term 'MAOI' means. (MAIO - monoamine oxidase inhibitor - is a type of antidepressant). In addition, the service user may not know whether the medicine that they are already taking falls into that category. There was no further information available on the website to explain what the term meant. This posed a risk that a patient could accidentally select the wrong answer and obtain a prescription for a medicine that they should not be taking.

The provider took immediate action to make the changes identified at the inspection and confirmed they would

review the language used in all current and future questionnaires to ensure medical jargon and terms not easily understood by service users would be changed and clarification added where required.

Once the GP selected the medicine and correct dosage, 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. No medicines were prescribed for unlicensed use. (Medicines are given licences after trials which show they are safe and effective for treating a particular condition. Use for a different medical condition poses a higher risk because less information is available about the benefits and potential risks).

Information about the different conditions treated was comprehensive and included a description of other treatments available, which included non-medicine based treatments.

Prescribing for long-term conditions was not available and we saw evidence of prescriptions being refused when patients were ordering too early and patients being directed to other services, such as the patient's GP, when this service was unable to help them.

From the patient records we reviewed we saw no evidence of medicines being prescribed inappropriately. Consultation templates were monitored by the provider to ensure that prescribing remained evidence based and in line with current guidelines.

Prescriptions were dispensed and delivered direct to the patient. The service had a system in place to monitor the quality of the dispensing process. The delivery process used included checks to ensure that the correct person received the medicine.

Information to deliver safe care and treatment

There were protocols in place for identifying and verifying the patient and ensuring that General Medical Council guidance was followed. However, photographic identification was not obtained.

The provider had good systems in place for ensuring that the people using the service were genuine. Staff used three different systems to verify the identity of service users. We were told that another system was due to go live immediately following the inspection which would strengthen the identify check process further.

On registering with the service, and at each consultation, patient identity was verified and the GP had access to the patient's previous records held by the service.

A suspicious activity log was kept to highlight any medicine request that raised concerns. Logs were also kept of people who were referred to their own GP as well as people who were refused medicines.

Management and learning from safety incidents and alerts

There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients. We reviewed four incidents and found that these had been fully investigated and discussed and as a result, action had been taken in the form of a change in processes. For example, monitoring had identified that a patient had been prescribed medicines although they were above the recommended age limit for the specific medicine. The reason for this was that date of birth checks were only carried out to ensure users were over 18 years old. As a result of this incident, the provider had implemented an age specific question and a date of birth check against the cut off year to ensure all patients were within the age range specified for the particular medicine.

We saw that the provider had an incident reporting form and incidents were logged and learning from incidents discussed by the providers and lead clinician at regular meetings. Minutes of the meetings and decisions and actions taken were recorded. A full audit trail was kept of correspondence with service users, including brief records of verbal conversations.

We saw evidence from incidents 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.

There were systems in place to deal with medicine safety alerts. We were given an example of a medicine which had been removed from the provider's formulary as a result of a safety alert. The provider had signed up to the Medicines and Healthcare products Regulatory Agency and Central Alerting Systems for receiving medical alerts via email. Alerts were checked at the start of each working day and if relevant, were actioned by the Superintendent Pharmacist.

Are services effective?

(for example, treatment is effective)

Our findings

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

Assessment and treatment

The clinical decision-making software used by the provider did not ask patients accessing the service for a full medical history. The online system required users to complete a questionnaire related to the medical condition that they were requesting medicines for. Patients were required to answer questions that assisted the software in deciding whether or not it was appropriate to prescribe the medicine. We noted that the language used in some of the questions may not have been understood by all service users. For example, one of the questionnaires asked: Are you allergic to Xenical or any of its constituents?

We also identified examples of drug interactions that were missing from three questionnaires. The provider took immediate action to correct this.

The responses to the questionnaires could only be a 'Yes' or 'No' answer. There was no option for patients to select 'Don't know'. However, there was a 'Chat with us' option visible to the service user at all times and a telephone contact number available for advice if the patient was unsure how to answer a question. This service was available during the service operating hours.

Each medicine had a bespoke questionnaire attached to it which included specific questions on past medical history, relevant to the treatment area selected, by asking if the patient suffered from a list of specific medical conditions. If the patient answered 'yes', the system would not allow the patient to continue with the questionnaire. Patients were also asked if they were taking specific medicines that could not be taken with the medicine being requested due to interactions. The structure of the form could be used to prompt the patient to supply a correct answer. For example, if a patient had answered 'yes' to a question when the answer should have been 'no', the system would immediately inform the patient that the consultation had to be terminated as the medicine was not suitable for them. If the patient changed their answer the consultation process would proceed.

We reviewed examples of medical records that demonstrated that patients' needs were assessed and care delivered in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) evidence based practice.

If insufficient information was available to reach a satisfactory conclusion, the provider would ask the patient to contact them by telephone or email. Telephone conversations were recorded.

We reviewed medical records which were all complete records and included all previous records.

The prescribing GP 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 and minimise the risks for patients. If the provider could not deal with a patient's request, this was adequately explained to the patient and a record kept of the decision.

The service monitored consultations and carried out consultation and prescribing audits to improve patient outcomes. We saw evidence that several audits were carried out and changes made as a result. For example, the provider noticed two suspicious activities where metronidazole (an antibiotic) was ordered for bacterial vaginosis by a male. In both cases the user was contacted and their partner placed the order themselves at a later date. Whilst bacterial vaginosis is a common condition that requires antibiotic treatment in certain situations, the provider decided to remove metronidazole as an available treatment and review again at a later date in line with their new antibiotic policy which reflected current guidelines for antibiotic prescribing.

Quality improvement

The service collected and monitored information on people's care and treatment outcomes. The service used information about patients' outcomes to make improvements.

The service took part in audit and quality improvement activity. For example, as a result of continuous monitoring of medicines usage, it was noted that there were higher than expected volumes of requests for Sumatriptan tablets (a treatment for migraine). The provider looked into the reason for this, and contacted the regional medicines Information Centre for further advice in this area.following

Are services effective?

(for example, treatment is effective)

discussions with the clinical team and further clinical research, carried out by the prescribing GP. The decision was agreed to limit the use of Sumatriptan to four treatments a month. Although there is limited clinical evidence to provide a definitive answer on Sumatriptan use, as some patients do require and benefit from frequent use, the provider felt that it was safer to set a limit through the online prescribing and refer all users who require and benefit from more frequent continuous use to their GP for further assessment as evidence supporting such high use was limited. Prescribing was therefore limited to treatment for four migraine episodes a month which was reflected in the on-line consultation form and the available quantity of 24 tablets every two months.

The provider was committed to the continual assessment and improvement of quality and had conducted medicines audits to assist in the identification of areas for improvement. This included audits of metronidazole use; trimethoprim use and suspicious activity.

Staff training

All staff had access to policies and procedures as required. A record of training carried out by the prescribing doctor was maintained. The provider maintained a training matrix which identified when training was due.

The GP told us they received excellent support if there were any technical issues or clinical queries and could access policies and procedures remotely. When updates were made to the IT systems the GP received further online training as appropriate.

The GP had received their annual GP appraisal and records were kept of this. The GP had not received an appraisal since working for the service but confirmed that when this was due he would ensure he informed his appraiser of his online prescribing work.

Coordinating patient care and information sharing

When a patient submitted the completed decision-making questionnaire, they were asked to confirm that they would inform their own GP of the medicines prescribed. Following dispatch, the patient was emailed by the provider giving the option for the patient to consent to the provider sharing details of the medicines prescribed with the patient's own GP. If patients gave their consent, a letter was sent to their registered GP in line with GMC guidance. There was a low uptake of this offer.

The service did not offer laboratory testing services.

Supporting patients to live healthier lives

The service had a range of information related to each treatment area available on the website (and links to other websites and blogs). This included information on smoking cessation, dietary advice and healthy living. This information provided comprehensive advice, including non-medicine based treatment options.

Are services caring?

Our findings

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

Compassion, dignity and respect

We were told by the GP that consultations were carried out in a private room and they were not disturbed during their working time. The provider carried out audits to ensure consultations and prescribing complied with the expected service standards and that communication with patients was appropriate and effective.

We did not speak to patients directly on the day of the inspection. However, we reviewed the latest survey information. At the end of every consultation, patients were encouraged to provide their feedback through 'Trustpilot' via the website. The survey score indicated that the majority of the 364 patients completing the survey were satisfied with the service: a score of 9.7 out of 10.

Involvement in decisions about care and treatment

There was comprehensive information and guidance provided for all treatment areas which were available to the patient before purchasing their medicines. The information included all treatment options available to the patient including non-medicine base treatments.

Information on the provider's website also informed patients about each medicine on offer including the price and whether the dose was low, standard or high.

The online system had a 'live chat' facility. This was in operation from Monday to Friday, 9am to 5pm, and Saturday 9am to midday. Users of the service could send instant messages to the pharmacists running the service.

Patients were able to access their medical records at any time via their login account.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting patients' needs

The service operating hours were from 9am to 5pm Monday to Friday and from 9am to midday on Saturday. During this time patients could speak directly to a member of staff.

Patients completed an online consultation form for a selected treatment area and specific medicine. This was then reviewed by the GP who issued a private prescription if deemed suitable. The prescription was then dispensed from the provider's affiliated pharmacy, ready for collection or delivery.

Prescribed medicines purchased before 4pm on a weekday and before 11am on a Saturday were dispatched the same day. Prescribed medicines purchased after these times were dispatched the following working day. Medicines were only prescribed to patients with an address in the UK.

The provider only offered treatment options that they considered could be appropriately managed through an online consultation form without the need for a face to face consultation. Patients were provided with all information relevant to the treatment area and medicine prescribed. Patients could contact the service for information or assistance, by email or telephone, at any time during operating hours.

The provider made it clear to patients what the limitations of the service were. It was not an emergency service. The on-line consultation template was designed to identify if a patient required urgent services and would therefore terminate the consultation process and advise the patient to seek medical attention.

The name and GMC number of the GP was available on the website.

Managing complaints

Information about how to make a complaint was available on the web site. The provider had implemented a complaints policy and procedure. The policy contained appropriate timescales for dealing with the complaint. There was escalation guidance within the policy. A form for the reporting of complaints was available on the web site. We reviewed complaints received by the service and noted that these were managed appropriately and reported in the patient's record.

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

The provider had also formulated an action plan following quarterly reviews of the survey results. For example,:

- In Quarter 1: two reviews had been received which gave 2 and 3 star ratings (out of 5 stars). These were both due to slow delivery times for orders placed over the weekend. It was agreed that the service needed to make delivery times clearer during the patient visit to the website to prevent misunderstandings over delivery times. As a result the following action was taken: The website developers were asked to integrate a tooltip in the checkout of the website which highlighted the delivery times patients should expect for each delivery option. This meant the patient could easily access this information when placing their order and did not have to divert to the delivery page.
- In Quarter 2: one 1 star review was awarded due to a patient claiming not to have received their order on two occasions. Investigations confirmed that the tracked delivery showed that someone with the patient's surname had signed for the parcel. Despite this the provider sent out a second parcel via Special Delivery to prevent any undue delay in their treatment. The patient claimed they never received the second item either, which was again tracked to the correct address. The provider responded to the review apologising and asked the patient to get in touch but they did not receive a response. As a result the following action was taken: All missing delivery claims were to be dealt with thoroughly to establish the location of the first parcel before sending out the replacement to ensure the patient did not receive unsafe quantities of medicines.

Consent to care and treatment

There was clear information on the website with regards to how the service worked and a frequently asked questions section for further supporting information. The website had a set of terms and conditions and details on how the

Are services responsive to people's needs?

(for example, to feedback?)

patient could contact the service with any enquiries. The patient was charged for the prescribed medicines only. Information about the cost of the medicine was known in advance and paid for before the item was dispensed.

Staff understood and sought patients' consent to care and treatment in line with current legislation and guidance. The GP and Registered Manager had received training in the Mental Capacity Act 2005. Consent to care and treatment was sought in line with legislation and guidance. Treatment was not provided for patients under 18 years old. If a patient's mental capacity to consent to care or treatment was unclear, clinical staff confirmed they would assess the patient's capacity and record the outcome of the assessment.

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 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 provide a high quality responsive service that put caring and patient safety at its heart. This was reflected in their business plan.

There was a clear organisational structure and personnel 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 annually and updated when necessary.

All appropriate policies and procedures were available and accessible to all personnel. However, not all policies were fully personalised to reflect the needs of the service or include a date of issue and date for future review.

There were a variety of daily, weekly and monthly checks in place to monitor the safety and quality of the service provided. This ensured that a comprehensive understanding of the performance of the service was maintained.

There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. The clinical team met weekly to discuss clinical governance and operational issues.

Treatment records were complete and securely stored. Records were kept of all interactions with patients including telephone contacts.

Leadership, values and culture

The directors of the company were both pharmacists and took responsibility for different aspects of the clinical and operational management of the service. One of the directors was the Registered Manager. They attended the service daily and were responsible for carrying out the daily operating processes of the service. There were systems in place to address the absence of the directors or GP.

The service had an open and transparent culture. We saw evidence that if there were unintended safety incidents, the service would give affected patients support, truthful information and a verbal or 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

The provider used a customer feedback system to collect feedback from users of the service. The system called 'Trustpilot' is an open system provided by a third party supplier. Any information that patients put onto the system could be seen by anyone accessing the website. This meant that patients were unlikely to put sensitive or personal information on the site.

The Trustpilot system enabled patients to rate the service they received. This was constantly monitored and if any negative comments or ratings were given this would trigger an immediate review to address any shortfalls and patients were contacted if their identity was known. Patients were also emailed at the end of each consultation to encourage them to complete the survey or to post any comments or suggestions online. Patient ratings were shown on the service website.

The provider informed us they were in the process of formulating a survey to be distributed using the 'Survey Monkey' system. This would allow the provider to gather additional and more specific patient feedback on predefined areas as the system also provides the option for patients to add free text to their feedback. This would enable the provider to collect data that would help them to improve the service.

There was evidence that the GP was able to provide feedback about the quality of the operating system and suggest clinical changes. Suggested changes were discussed at minuted clinical governance meetings attended by all three clinicians. All change requests were logged, discussed and decisions made for the improvements to be implemented.

Are services well-led?

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

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 Registered Manager was the named person for dealing with any issues raised under whistleblowing.

Continuous Improvement

The service consistently sought ways to improve. All personnel were involved in discussions about how to develop the service and were encouraged to identify opportunities to improve the service delivered.

The provider was in the process of developing personalised blogs and vlogs for patients relating to their specific treatment area. These would be attached to the patients account to encourage them to access the information.

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 How the regulation was not being met: The provider was not doing all that is reasonably practicable to mitigate risks to service users regarding the proper and safe management of medicines. The provider did not ensure that consultation questionnaires included all relevant information nor that the language used could be easily understood by all service users. This was in breach of regulations 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.