DiMedic Limited

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Inspection report

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Overall summary

Letter from the Chief Inspector of General Practice

We previously carried out an announced comprehensive inspection at DiMedic Limited on 16 November 2017 during which we found the service was not providing safe services and issued a requirement notice. However, we found they were providing effective, caring, responsive and well-led services in accordance with the relevant regulations. The full comprehensive report on this inspection can be found by selecting the 'all services' link for location name on our website at www.cqc.org.uk.

We carried out this announced focused inspection at DiMedic Limited on 18 September 2017. We inspected the 'Are services safe?' key question to check the service met the requirements of regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment and had made the necessary improvements.

DiMedic Ltd provides an online clinic, consultation, treatment and prescribing service for a limited number of medical conditions to patients primarily from England, Poland and Germany. As the provider's website was in Polish the service could only be accessed by Polish speaking patients.

Our findings in relation to the key questions were as follows:

Are services safe? – we found the service was providing a safe service in accordance with the relevant regulations. Specifically:

- Arrangements were in place to safeguard people, including arrangements to check patient identity. Where a patient consented there were processes in place to share information with their own GP.
- There were systems in place to receive, disseminate and consider National Institute for Health and Care Excellence (NICE) and other clinical guidelines and national patient safety alerts.

The area where the provider should make improvement is:

- Develop and implement processes, in line with GMC guidance, for communicating with patients who choose not to consent to information about their participation in the programme being shared with their registered GP.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

DiMedic Limited

Detailed findings

Background to this inspection

DiMedic Ltd provides an online clinic, consultation, treatment and prescribing service for a limited number of medical conditions to patients primarily from England, Poland and Germany. The conditions treated are limited to hair loss, contraception, male thrush, vaginal thrush, smoking cessation, premature ejaculation, erectile dysfunction, menopause, cystitis, migraine and obesity. A specific list (with photographs) of medicines that the provider is able to prescribe to treat these conditions is detailed on the provider's website. The service does not treat patients under the age of 18 and does not prescribe any pain relief or high risk medicines. They prescribe one type of antibiotic for a specific condition and for a limited period of time only.

DiMedic Ltd consists of five members of staff which includes a pharmacist/registered manager, three doctors and a deputy registered manager. The doctors, who are GPs and registered with the General Medical Council (GMC), are contracted to undertake remote patient consultations by reviewing patient requests and completed medical questionnaires when they apply for medicines on-line.

The service's call centre is open between 9am and 5pm on a Monday to Friday. However, patients are able to submit a request for treatment 24-hours a day, seven days a week on the provider's website. Requests for treatment are generally dealt with within one to three working days depending on when they are received.

This is not an emergency service. Subscribers to the service pay for their medicines when their on-line application has been assessed and approved. Once approved by the prescriber, prescriptions are issued by post.

DiMedic Ltd is operated via a website (http://dimedic.eu) which is currently only available in Polish. The provider is in the process of introducing an English version.

How we inspected this service

We carried out an announced inspection of this location on 18 September 2018. We visited the DiMedic operating site in Newcastle Upon Tyne and spoke to their medical director and the registered manager. We looked at the records, policies and other documentation the provider maintained in relation to the provision of services.

To get to the heart of people's experiences of care, we ask the following five questions of every service and provider:

- 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.

Our inspection team was led by a CQC Lead Inspector.

Why we inspected this service

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 that improvements had been made at the service following our comprehensive inspection on 16 November 2017 and whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Are services safe?

Our findings

At our previous inspection on 16 November 2017 we found the service had not fully assessed the risks to the health and safety of patients receiving care and treatment. We issued a requirement notice in relation to Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment.

At this inspection, 18 September 2018, we found the service had addressed the issues identified at the last inspection.

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

Keeping people safe and safeguarded from abuse

In November 2018, we found the safeguarding policy did not make it clear that concerns should be reported to the local authority where the patient resided.

In September 2018, we found the provider had updated their safeguarding policy to include details of how to contact relevant local authorities should concerns arise in relation to patients resident in England.

Monitoring health & safety and responding to risks

In November 2017, we found the provider did not have a process in place to discuss or monitor the implementation of NICE guidance and told us that they relied on the GP obtaining relevant information through their role in the NHS.

In September 2018 we found arrangements had been implemented to keep clinical staff up-to-date with NICE and other relevant guidance. They had implemented quarterly clinical meetings, where these were a standing agenda item. They had created a resource pack on the provider's shared drive for ease of reference to guidelines relevant to the range of conditions treated and medicines prescribed. They had also created an induction pack to update new staff about relevant guidelines. They showed us a sample of patient records where requests for medicines were rejected, in line with national guidelines, as patients were contraindicated for the medicines.

Prescribing safety

In November 2017, although there were some protocols in place for identifying and verifying the patient we were not assured that these would prevent fraudulent or inappropriate requests for service from patients within England. In September 2018, we found the service had made improvements. Patients were required to undergo verification processes, prior to provision of the service. This was achieved by either the patient undertaking a nominal bank transfer or providing identity documents (such as driving licence or passport) to prove their identity. If a patient was unable to verify their identity their request for service was refused. There were processes in place to ensure multiple requests from the same person were not submitted via different accounts. Prior to implementing this change, we were told the provider had written to all existing account holders to inform them of the new identity verification system.

At the last inspection, we also found the provider did not have a system in place to gain details of a patient's own GP or to ask patients if details of their consultation could be shared with their registered GP. In September 2018, the service had addressed this by amending their website to include this facility. Where a patient indicated they wished the information to be shared, this generated a letter. The provider told us this letter was then sent by recorded delivery to the GP practice of choice. This facility was in place from July 2018, but as yet no patient had consented to their information being shared with their own GP.

Management and learning from safety incidents and alerts

In November 2017, the provider did not have a significant event or incident policy. The provider did not have a system in place to receive or disseminate national patient safety alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA).

In September 2018, we found improvements had been made. A significant events policy was now in place. The medical director had signed up to all relevant national patient safety alerts through the central alerting system and the Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit. There was a standing agenda item on the quarterly clinical meeting to discuss any relevant alerts received with all staff.