FMC Marketing Ltd

Inspection report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

Letter from the Chief Inspector of General Practice

We rated this service as Requires improvement overall. (Previous inspection 30 May 2018, when we found the provider was meeting the relevant standards)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection at FMC Marketing Ltd on 11 April 2019, as part of our inspection programme.

FMC Marketing Ltd has management offices at 69 Old Street, EC1V 9HX London. It is run by two directors who are based at the management offices, and two GPs who work remotely from the management offices. It operates as an online doctor service via the following four websites: www.deutsch.prima-med.com; www.firstmed.co.uk; www.pharma.myonlinedoctor.co.uk; and www.myonlinedoctor.co.uk.

At this inspection we found:

- Staff personnel files we looked at did not contain evidence of up to date mandatory training.
- Not all prescribing was within national guidelines.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- Patients could access care and treatment from the service within an appropriate timescale for their needs.
- There were no medical health questionnaires to identify age-related health issues amongst the service's aging patient population
- There was a clear organisational structure and staff were aware of their roles and responsibilities.

The areas where the provider **should** make improvements are:

- Consider updating service websites to provide links to additional sources of information about health conditions.
- Encourage patients to re-complete a full health history questionnaire on a regular basis to ensure the service has full knowledge of any changes in patient's health since a full medical history was last taken.
- Review and encourage all staff to undertake mandatory skills training on a regular basis.
- Consider changing the system for reviewing alerts coming into the service to ensure these are always seen and acted upon by a clinician.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

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

Background to FMC Marketing Ltd

Background

FMC Marketing Ltd was established in 2003 to provide an online consultation, treatment and prescribing service for a limited number of medical conditions to patients in the United Kingdom, Germany, Scandinavia and Portugal. Its management offices are at 69 Old Street, London, EC1V 9HX. The provider carries out asynchronous (text based) consultations and the doctor contacts patients where necessary to clarify answers given.

A registered manager is 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.

The conditions treated are: weight loss, hair loss, contraception, anti-malaria, period delay, smoking cessation, allergy management, acne and erectile dysfunction. The service's call centre is open between 10am and 3pm Monday to Friday. However, patients are able to complete and submit consultation forms to request treatment 24 hours a day, seven days a week on the provider's websites. Requests for treatment received up to 3pm on a weekday are normally dealt with within a three-hour timescale. Other requests are dealt with the following working day. It is not an emergency service.

Once the doctor approves a prescription it is sent to the designated pharmacy. The pharmacy dispenses the medicines and posts them to the patients nominated address.

How we inspected this service

This inspection was carried out a CQC Lead Inspector, GP specialist Advisor, CQC Pharmacist and a second CQC Inspector.

Before the inspection we gathered and reviewed information from the provider. During this inspection we spoke to the two directors of the service and the GP who undertakes consultations and prescribing. The other GPs role is to undertake consultation and prescribing audits.

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

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

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

Good

Are services safe?

We rated safe as Good because:

- There were enough staff, including GPs, to meet the demands for the service.
- The GP could only prescribe from a set list of medicines which the provider had risk-assessed.
- There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members.

Keeping people safe and safeguarded from abuse

Staff employed at the headquarters had received training in safeguarding and whistleblowing and knew the signs of abuse. All staff had access to the safeguarding policies and where to report a safeguarding concern. In the event of a need to report a safeguarding issue, the service's safeguarding policies contained links to enable it to contact the appropriate team dependent on where the patient resided. The GP had received adult and level three child safeguarding training. It was a requirement for GPs registering with the service to provide evidence of up to date safeguarding training.

The service did not treat children. It relied on an external reference checking agency to verify identity and ages of patients to ensure no one under 18 accessed the service.

Monitoring health & safety and responding to risks

The provider headquarters was located within purpose-built offices which housed the IT system and the non-clinical staff. Patients were not treated on the premises as the GP carried out the online consultations remotely; usually from their home. Staff based at the premises had received training in health and safety including fire safety, however training updates had not been undertaken within the last 12 months, and there was no evidence on file the GP had completed updates of all training the service deemed mandatory.

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

There were processes in place to manage any emerging medical issues during a consultation. The service was not intended for use by patients with either long term conditions or as an emergency service. The conditions treated did not normally give rise to an emergency, in addition, consultations were based on the GP reviewing an online application. In the event the consultation request gave rise to any need to urgently contact the patient the GP was able to message the patient. Patient records also contained their home address so emergency services could be alerted to attend their address if necessary.

All clinical consultations were rated by the GP for risk. For example, if the GP thought there may be serious mental or physical issues which required further attention, the GP could send a message to the patient to provide advice. In such circumstance's patients would be recommended to contact their NHS GP. There were protocols in place to notify Public Health England of any patients who had notifiable infectious diseases.

A range of clinical and non-clinical meetings were held with staff, where standing agenda items covered topics such as significant events, complaints and service issues. Clinical meetings also included case reviews and clinical updates. We saw evidence of meeting minutes to show some of these topics had been discussed, for example to encourage patients to provide contact details for their NHS GP and to consent to information sharing with their GP. The provider had reviewed and assured itself it was complying with the latest CQC approved guidance for ID checking.

Staffing and Recruitment

There were enough staff, including GPs, to meet the demands for the service, the numbers of consultations had declined as the service continued to provide repeat prescriptions for its cohort of long-term patients. Accordingly, the service only employed one GP to undertake consultations. The prescribing GP was paid on a sessional basis.

The provider had a selection and recruitment process in place for all staff. There were a number of checks required to be undertaken prior to commencing employment, such as references and Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)

Potential GP employees had to be currently working in the NHS as a GP and be registered with the General Medical Council (GMC) and on the GP register. They had to provide

evidence of having professional indemnity cover, an up to date appraisal and certificates relating to their qualifications and training in safeguarding and the Mental Capacity Act.

Newly recruited GPs were supported during their induction period and an induction plan was in place to ensure all processes had been covered.

We reviewed two personnel files. The GP personnel file showed the GP had provided necessary documentation when starting with the service, including their qualifications and registration with relevant bodies in line with the providers policy.

Prescribing safety

All medicines prescribed to patients from online forms were monitored by the provider to ensure prescribing was evidence based. If a medicine was deemed necessary following a consultation, the GP could issue a private prescription to patients. The GP could only prescribe from a set list of medicines which the provider had risk-assessed. We saw there were no controlled drugs on this list, or of medicines that required ongoing monitoring.

The online forms patients completed had not been revised to manage the aging demographic of the patient population, nor did they ask appropriate questions to ascertain patients state of mental health which was relevant to establish prior to prescribing some of the medicines the service offered. Following our inspection, the service confirmed it would implement a procedure to require patients to re-complete a full medical history every 12 months. This would ensure that any health issues that had previously been forgotten, and any newly arising health issues, would be brought to the attention of the doctor. The service recognised the importance of maintaining up to date health records to ensure that all prescribing remained appropriate.

Once the GP prescribed the medicine of choice, relevant instructions were given to the patient regarding the dosage and 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.

The service did not prescribe any medicines for patients with long term conditions which would need to be monitored. The service only prescribed topical antibiotics for the treatment of acne. It encouraged good antimicrobial stewardship by only prescribing from a limited list of antibiotics which was based on national guidance.

The IT system used by the provider prevented patients from accessing multiple prescriptions as far as possible by checking for duplicate names, postcodes and email addresses. There were protocols in place for identifying and verifying the patient and General Medical Council guidance, or similar, was followed.

Once approved by the prescriber, prescriptions were issued to one of the pharmacies used by the service who were contracted to supply the prescribed course of treatment. The service had a system in place to assure themselves of the quality of the dispensing process. There were systems in place to ensure the correct person received the correct medicine.

Information to deliver safe care and treatment

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

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 and staff members. We reviewed two incidents and found these had been fully investigated, discussed and as a result action taken in the form of a change in processes. For example: a patient had complained about being supplied with a generic medicine rather than a branded version of the same medicine. The service raised this with the pharmacy who explained that the generic medicine had the same amount of the active ingredients as the branded version. Nevertheless, the pharmacy gave the patient a partial refund as a gesture of goodwill.

The service kept a record of medicines alerts from MHRA. However, these were reviewed by one of the directors who did not have the clinical expertise to establish direct and indirect applicability to the medicines prescribed by the service. Following our inspection, the service advised that it would introduce a system whereby all MHRA alerts received

Good

Are services safe?

by the directors would be passed to the GP. The GP would determine the relevance of the alert and advise the directors accordingly. They in turn would update the alerts register.

Learning from incidents was discussed with staff as and when they happened and more formally at quarterly review meetings. We saw evidence from events 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. All staff had undertaken duty of candour training.

There were systems in place to ensure the correct person received the correct medicine.

Good

Are services effective?

We rated effective as Good because:

- The service used information about patients' outcomes to make improvements.
- The provider had risk assessed the treatments it offered.

Assessment and treatment

We reviewed 10 anonymised medical records. Most records we reviewed demonstrated the GP assessed patients' needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) evidence based practice. However we found the notes recorded for two of the ten consultations we looked at showed prescribing was not within national guidelines. For example, one record we looked at showed a medicine was continuing to be prescribed to a 49-year-old patient, despite the GP confirming once patients seeking such medicine reached age 45-46 they would advise them to return to their NHS GP to continue prescribing as the NHS GP would be better placed to monitor age related risk factors. The prescribing for another patient disclosed an issue with the consultation template as there were no questions about the state of patient's mental health, despite MHRA alert evidence that in some cases the treatment could lead to depression or suicidal thoughts.

Following our inspection, the service implemented changes to its system to: ask questions about the patient's state of mental health and to ask them to tick a box to indicate that any such issues would be advised to the service's GP or their NHS GP.

We were told each consultation lasted approximately five minutes for repeat prescriptions and 10 minutes for new prescribing. If the GP had not reached a satisfactory conclusion there was a system in place to enable them to contact the patient again.

Patients completed an online form which included their past medical history. There was a specific template to complete for the consultation which varied according to the medical issue. It included the reasons for the consultation and the outcome was manually recorded, along with any notes about past medical history and diagnosis. We reviewed 10 anonymised medical records which were complete records. The GP had access to all previous notes.

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 and minimise the risks for patients. If a patient needed further examination they were directed to an appropriate agency, such as their NHS GP. For clinical guidance the GP referred to NICE guidelines and to NICE Clinical Knowledge Summaries (CKS). Nice CKS provided current evidence based and practical guidance on best practice in respect of over 330 common and/or significant primary care presentations. If the provider could not deal with the patient's request, this was explained to the patient and a record kept of the decision.

The service monitored consultations and carried out consultation and prescribing audits to improve patient outcomes

Quality improvement

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

- The service used information about patients' outcomes to make improvements.
- It took part in quality improvement activity, for example audits, reviews of consultations and prescribing trends. For example, the IT system randomly generated a list of five-percent of patient online consultations. These interactions were then peer reviewed by the other doctor.
- The service had noted from its audit activity its service was gradually declining in size. It had no intention of introducing additional treatments.

Staff training

All staff completed induction training which consisted of: the aims and objectives of the service; the rights of patients who use the service; review of the policies and procedures; action to be taken in an emergency; how to report adverse events, accidents, incidents, errors and near misses; how to report when the service falls below the CQC fundamental standards of quality and safety; and support and safety arrangements if required to work alone. Staff also completed other training the service considered mandatory, including, health and safety, basic life, support

Good

Are services effective?

fire safety, infection prevention and control, Mental Capacity Act, and information governance. However, records we looked at showed staff had not received updated mandatory training within the last 12 months.

The GPs registered with the service received specific induction training prior to treating patients. The GP told us they received excellent support if there were any technical issues or clinical queries and could access policies. When updates were made to the IT systems, the GP received further online training.

The GP had to have received their own appraisal before being considered eligible at the recruitment stage. The GP received an annual appraisal by the service every year. This included a review of performance and any areas where there was a need for further training. It also set goals for the forthcoming year. The service required the GP to declare their online work as part of their external appraisal.

Coordinating patient care and information sharing

Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history.

All patients were asked for consent to share details of their consultation and any medicines prescribed with their registered NHS GP on each occasion they used the service.

The provider had risk assessed the treatments it offered. It only provided prescriptions for a limited range of conditions it had assessed as being low-risk. The service did not prescribe medicines not suitable for prescribing if the patient did not give their consent to share information with their GP, or they were not registered with a GP. For example, medicines liable to abuse or misuse, and those for the treatment of long-term conditions such as asthma. The service had achieved 72% of patient records containing GP contact details, however, only a very small number of patients had consented to sharing of this information with their GP. The service rationalised most of the issues for which they provided prescriptions were sensitive or potentially embarrassing, such as erectile dysfunction, hair loss and premature ejaculation. Following the inspection, the service advised that it would change its terms and conditions and add a statement for patients to consent to information sharing with their NHS GP where the prescriber had serious concerns about the patients' health and well-being.

The service agreed it provided only a very small number of prescriptions to new patients, so was effectively servicing an aging population who would, therefore, benefit from information sharing with their NHS GP.

It did not make referrals or require patients to have blood tests. As the service only offered prescriptions for a range of low-risk medicines, if a patient consultation disclosed the need for a referral or blood test, the service would recommend the patient returned to their NHS GP.

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 in an aftercare message it sent out to patients following consultations.

Consent to care and treatment

There was clear information on the service's website with regards to how the service worked and what costs applied including a set of frequently asked questions for further supporting information. The website had a set of terms and conditions and details on how the patient could contact the service with any enquiries. Information about the cost of the consultation was known in advance and paid for before the consultation commenced. The costs of any resulting prescription or medical certificate were handled by the administration team at the headquarters following the consultation.

The GP had received training about the Mental Capacity Act 2005. Staff understood and sought patients' consent to care and treatment in line with legislation and guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP was capable of assessing the patient's capacity and, would record the outcome of the assessment. The process for seeking consent was monitored through audits of patient records.

Good

Are services caring?

We rated caring as Good because:

- Patient satisfaction levels were very high with 96% of patients being satisfied or very satisfied with the service received.
- Patients had direct access to their previous consultation records by logging onto their account with the service.

Compassion, dignity and respect

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

We did not speak to patients directly on the day of the inspection. However, we reviewed the latest survey information. Following every consultation, patients were sent a message asking for their feedback. We reviewed patient responses over the last seven days and found 26 (96%) out of 27 patients had indicated they were satisfied or very satisfied with the service received.

Involvement in decisions about care and treatment

Patient information guidance about how to use the service and technical issues were available. There was a dedicated team to respond to any enquiries.

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

The latest survey information available from two responses indicated both patients were satisfied with the explanation of their condition. Patients were similarly satisfied with the ease of navigating the website and with the ease of answering the questions asked.

Patients could access details of all previous orders and consultation records by logging on to their account with the service.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

- The provider's websites made clear what services were available.
- The provider offered consultations to anyone over the age of 18 who requested and paid the appropriate fee and did not discriminate against any client group.
- Information about how to make a complaint was available on the service's web site.

Responding to and meeting patients' needs

The service's websites were available 24 hours a day, seven days a week, and their call centre was open on Monday to Friday between 10.00am and 3.00pm. Requests for treatment received up to 3.00pm on a weekday were generally dealt with within a three-hour timescale. Other requests were dealt with the following working day. The provider's websites made clear what services were available. This service was not an emergency service, and patients who had a medical emergency were advised to seek immediate medical assistance via their own GP, 999 or the NHS 111 service.

The digital application allowed people to contact the service from abroad, but all medical practitioners were required to be GMC registered and based within the United Kingdom. Any prescriptions issued were delivered within the UK, it was clear to patients they could only use a dedicated pharmacy.

Patients signed up to receiving this service on a computer or mobile phone or another internet connected device. The service did not offer appointments but processed patient form-based consultations in the order of receipt.

The provider made the limitations of the service clear to patients.

Tackling inequity and promoting equality

The provider offered consultations to anyone over the age of 18 who requested and paid the appropriate fee and did not discriminate against any client group. If a patient could not submit their request through the website due to a disability the provider told us they made arrangements for a member of staff to discuss this over the telephone and input the information for them.

Patients could access a brief description of the GP.

Managing complaints

Information about how to make a complaint was available on the service's web site. The provider had developed a complaints policy and procedure. The policy contained appropriate timescales for dealing with the complaint. There was escalation guidance within the policy. A specific form for the recording of complaints had been developed and introduced for use. We reviewed the complaint system and noted comments and complaints made to the service were recorded. We reviewed two complaints out of seven received in the past 12 months.

The provider was able to demonstrate the complaints we reviewed were handled correctly and patients received a satisfactory response. There was evidence of learning as a result of complaints, changes to the service had been made following complaints, and had been communicated to staff.

Good

Are services well-led?

We rated well-led as Good because:

- There was a clear organisational structure and staff were aware of their own roles and responsibilities.
- Patients could rate the service they received.
- The values of the service were to deal with patients in a sensitive and caring way.

Business Strategy and Governance arrangements

The provider told us they had a clear vision to work together to provide a high-quality responsive service putting caring and patient safety at its heart. We reviewed the service's business plan which covered the service's continued existence. The service had no plans to increase the range of conditions for which it would provide treatment, nor was it actively pursuing growth of the population groups it served.

There was a clear organisational structure and staff were aware of their own roles and responsibilities. There was a range of service specific policies which were available to all staff. These were reviewed annually and updated when necessary.

There were a variety of daily, weekly and monthly checks in place to monitor the performance of the service. These included random spot checks for consultations. The information from these checks was used to produce a clinical team report was discussed at regular team meetings. This ensured 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.

Care and treatment records were complete, and securely kept. However, the records did not provide space for the GP to add or edit information to ensure that more detailed notes were kept. Following our inspection, the service advised that it would implement a change to the patient record system to allow the GP to enter patient notes and to edit those to provide additional information.

The online forms patients completed had not been revised to manage the aging demographic of the patient population, nor did they ask appropriate questions to ascertain patients state of mental health which was relevant to establish prior to prescribing some of the medicines the service offered. Following our inspection, the service confirmed it would implement a procedure to require patients to re-complete a full medical history every 12 months and would add additional questions to ascertain the state of patient's mental health.

Leadership, values and culture

The two directors of the company were responsible for the day to day running of the service. One of the directors acted as registered manager and was responsible for regulatory compliance and clinical matters. The other was responsible for financial matters, and patient and commercial services.

The values of the service were to deal with patients in a sensitive and caring way.

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

Safety and Security of Patient Information

Systems were in place to ensure 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. The GP, an employee of the service, did not hold patient records so was not required to register with the Information Commissioners 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

Patients could rate the service they received. This was constantly monitored and if it fell below the provider's standards, this would trigger a review of the consultation to address any shortfalls. In addition, patients were sent a message following each consultation with a link to a survey they could complete or could also post any comments or suggestions online. Questions asked included: the ease of navigating the website and with the ease of answering the questions.

Good

Are services well-led?

There was evidence the GP could provide feedback about the quality of the operating system and any change requests were logged, discussed and decisions made for the improvements to be implemented.

The provider had a whistleblowing policy in place. (A whistle blower is someone who can raise concerns about practice or staff within the organisation.) The 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.

We saw from minutes of staff meetings where previous interactions and consultations were discussed.

As the management team worked together at the headquarters there were ongoing discussions at all times about service provision.

There was a quality improvement strategy in place to monitor quality and to make improvements, for example, through clinical audit. The service ran a monthly patient satisfaction survey. We looked at patient responses over the last seven days and found 26 (96%) out of 27 patients had indicated they were satisfied or very satisfied with the service received.