Index Medical Limited

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Inspection report

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Overall summary

Letter from Chief Inspector of General Practice

We previously inspected Index Medical Limited on 4 May 2017. The full comprehensive report on the May 2017 inspection can be found by selecting the 'all services' link for location name on our website at www.cqc.org.uk.

At the May 2017 inspection we found the service was not meeting some areas of the regulations in that it was not providing Safe and Well-led services. However, we found it was providing Caring, Effective and Responsive services in accordance with the relevant regulations.

Following the May 2017 inspection, we issued Requirement Notices to the provider when the report of the inspection was published on 10 July 2017.

We carried out an announced focused inspection at Index Medical Limited on 14 December 2017. This inspection covered the Safe and Well Led key questions to confirm the provider had carried out their plan to meet legal requirements in relation to the breaches of regulations identified in our May 2017 inspection. This report covers our review of the Requirement Notices and findings in relation to those requirements.

Index Medical Limited provides an online primary care consultation service and medicines ordering service. Patients register for the service on the provider's website. We inspected both online services known as Dr Fox online doctor and pharmacy (www.doctorfox.co.uk); and Fast Doctor on line prescriptions (www.fastdr.com). We did not inspect the provider's affiliated pharmacy which is based in Scotland.

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; and found the issues in the Requirement Notices had been addressed. Specifically:

- Arrangements were in place to safeguard people, including arrangements to check patient identity.
- Prescribing was in line with national guidance, including taking account of medicines safety alerts; and people were told about the risks associated with any medicines used outside of their licence.
- Suitable staff were employed and appropriately recruited.

Are services well-led? - we found the service was providing a well-led service in accordance with the relevant regulations; and found the issues in the Requirement Notices had been addressed. Specifically:

- The service had appropriate insurances in place.
- Staff records were complete and up to date including records of Disclosure and Barring Service (DBS) checks and confidentiality agreements.

Summary of findings

- Clinical input, to ensure consultation templates were up to date, was provided by GPs who were registered with the General Medical Council (GMC).

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?
We found the service was providing a safe service in accordance with the relevant regulations; and found the issues in the Requirement Notices had been addressed.

Are services well-led?
We found the service was providing a well-led service in accordance with the relevant regulations; and found the issues in the Requirement Notices had been addressed.

Index Medical Limited

Detailed findings

Background to this inspection

Background

Index Medical Limited is based in Westbury-on-Trym, Bristol. Index Medical Limited set up an online service in January 2010 which includes a remote consultation with a GP. We did not inspect the provider's affiliated pharmacy which is based in Scotland. We inspected both online services known as Dr Fox online doctor and pharmacy and Fast Doctor on line prescriptions at the address from which the provider is registered to provide services:

60 City Road, St Pauls, Bristol, BS2 8TX.

At the time of the inspection there were two directors of the service supported by three contracted GPs and they also employed a governance officer and a customer services assistant. Dr Fox and Fast Doctor had approximately 200,000 patients registered. Since its launch there have been approximately 500,000 requests for prescriptions. The service can be accessed through their websites, www.doctorfox.co.uk and www.fastdr.com where patients can place orders for medicines. The service is available for patients in the UK and in the EU. Patients can access the service by phone or e-mail from 9am to 5pm, Monday to Saturday.

The service is not intended to be used in an emergency and patients under the age of 18 are not treated. On the service's website patients select the medicine they wish to be prescribed and then complete a consultation questionnaire. Patients do not have to pay to register with the service in order to do this. Patients pay for their medicines when making their on-line application. If approved by the prescriber, medicines via the Dr Fox website are dispensed, packed and delivered by a third party tracked and secure courier service. Medicines prescribed via the Fast Doctor website are collected from an affiliated pharmacy chosen by the patient at the time of ordering. In the event that GPs reject a prescription request, refunds are made to the patient at this point.

Index Limited is registered with Care Quality Commission (CQC) and has a registered manager in place. 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.

How we inspected this service

This inspection was carried out on 14 December 2017 by a CQC lead inspector. Before the inspection we gathered and reviewed information from the provider relating to the improvements implemented since the May 2017 inspection. During this inspection we spoke to the Registered Manager and members of the management and administration team.

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. For this follow up inspection we focused on questions relating to whether the service provided was safe and well led, including the issues in the Requirement Notices.

Why we inspected this service

Detailed findings

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Are services safe?

Our findings

At our previous inspection on 4 May 2017 we found the service was not providing services that were safe and issued a Requirement Notice in that the provider must ensure care and treatment are provided in a safe way for service users. We found that the provider had not done all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. In particular we reported that the provider must:

- ensure safe management of medicines in relation to the issuing of prescriptions for reliever inhalers for asthma.
- have an effective system in place to check the identity of patients using the service.
- ensure effective systems were in place for safeguarding.

We also recommended that the following areas could be improved:

- systems and processes should be reviewed for patients to acknowledge and consent to being prescribed medicines for unlicensed use.
- introduce a process to review patients who may have been prescribed medicines which were the subject of medicine alerts issued by the Medicines and Healthcare products Regulatory Agency (MHRA).
- Review arrangements for amendments to consultation questionnaires that were made by a GP without a licence to practice.

At this inspection, 14 December 2017, we found the service had addressed the issues identified at the last inspection. We found that this service was providing safe care in accordance with the relevant regulations. Examples of the improvements seen included:

The provider web site stated that patients could receive an average of one inhaler per month; that all inhaler patients were required to provide GP details; and patients were informed that their GP would be informed of the treatment provided.

We saw that the on line consultation template that patients completed included this information. We saw examples of the letters sent to GPs, providing information on treatment provided, and an advice leaflet for patients. We saw a documented review of the consultation process for inhalers, with evidence of input from GPs registered to practice.

A new system for identity checks had been developed and implemented in November 2017. We saw an updated procedure document and examples of the ID checking process in use. This included using an independent computer system that provided instant on line checks against multiple credit reference agencies and other personal data. The payment process also used an extra payment security check system. We saw that any identity details entered by the patient that were not instantly verified resulted in a requirement to securely submit photographic ID. This was then checked by staff against the patients' account details and if there were further queries the patient was contacted by staff. We saw this process in use including, for example, orders that had been quarantined until ID confirmed; or, if rejected, payment refunded. The procedure required all deliveries to be signed for by an adult. The system alerted administration staff where any duplicate or near duplicate account details were entered by patients and these were followed up with patients and any duplicate records were amalgamated.

Updated safeguarding policies for children and vulnerable adults were in place and both included a named GP as lead. We saw evidence of adult and level three child safeguarding training for the lead GP and adult safeguarding training for other GPs. The service did not treat children.

There were examples of clear written notification to patients and additional advice and information documents in place for each medicine used outside of its licence. (Medicines are given licences after trials have shown that they are safe and effective for treating a particular condition. Use for a different medical condition is called unlicensed use and is a higher risk because less information is available about the benefits and potential risks). For example, for the treatment of jet lag we saw questions in the medical questionnaire that patients completed to acknowledge and agree to off-licence use of the medicine prescribed; along with additional information and advice that was provided to the patient.

The processes to ensure patient safety alerts issued by the Medicines and Healthcare products Regulatory Agency (MHRA) had been implemented to ensure they were

responded to consistently and appropriately. We saw that an updated process for safety alerts was in place and examples where alerts had been identified as relevant and action taken. There was evidence that alerts had been shared with the GPs; patients had been informed; and alerts had been discussed at team meetings. However, the provider suggested the process could be further improved by implementing a spreadsheet record to confirm all alerts had been received, reviewed, action taken where relevant and actions were completed. After the inspection we received a copy of the spreadsheet that had been introduced confirming that this improved process had been implemented.

Plans were in place for reviews of consultation procedures, with arrangements to review all templates over a 24 month period. We saw examples of two completed reviews of consultation templates, including comments and amendments from GPs, and a third that was currently underway. The GPs were registered with the General Medical Council (GMC) and were listed on the GP register. We saw evidence in minutes of team meetings that plans for and reviews of consultation templates were discussed. We also saw evidence of reviews of prescribing for each GP and positive feedback received from patients.

Are services well-led?

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

Our findings

At our previous inspection on 4 May 2017 we found the service was not providing services that were well led and issued a Requirement Notice in that the provider must operate effective systems and processes to make sure they assess and monitor the service. We found that the provider had failed to assess, monitor and mitigate risk relating to the health, safety and welfare of service users and others who may be at risk which arise from carrying out on the regulated activity.

In particular we reported that the provider must:

- ensure appropriate insurances were in place.
- ensure Disclosure and Barring Service (DBS) checks were up to date.
- ensure systems and processes were in place to protect patient's confidentiality.
- ensure amendments to consultation templates had oversight from licensed to practice clinicians.

We also recommended that the following areas could be improved:

- review systems and processes with regards to record keeping of inductions undertaken by new staff.

At this inspection, 14 December 2017, we found the service had addressed the issues identified at the last inspection. We found that this service was providing well led care in accordance with the relevant regulations. Examples of the improvements seen included:

We saw evidence of insurance in place with current certificates covering the period from 05/05/17 to 04/05/18 for employer's liability and public liability. We saw current medical indemnity insurance certificates in place for all the GPs, covering a total of nine sessions per week.

Evidence of recent enhanced DBS checks, along with photographic ID; and signed confidentiality agreements, was on file for all staff.

We saw examples of completed and ongoing reviews of consultation templates, showing comments and amendments by the GPs who conduct consultations. Amendments had been suggested, following medical alerts and updated evidence based clinical guidance, and had been included in the current templates. For example, the template for asthma had been reviewed in September 2017 and we saw records showing comments made by each GP with references to relevant clinical guidance. We saw similar evidence for reviews of the template for hair loss in August 2017; and the template for cystitis in December 2017. In total, 11 templates had been reviewed between June and December 2017. All GPs employed to conduct consultations and comment on templates were registered with the General Medical Council (GMC).

An updated staff recruitment policy was in place, including an induction training plan template. No new staff had been recruited since 2013, thus the induction training template had not yet been used. However, we saw notes on file of the induction activities planned and completed when the most recent employee started their employment.