Doctor Matt Ltd

Doctor Matt Ltd

Inspection report

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Ratings

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Doctor Matt Ltd on 10 January 2017. Dr Matt is an online service providing patients with prescriptions for medicines that they can obtain from the affiliated registered pharmacy

We found this service did not provide safe, effective, responsive and well led services in accordance with the relevant regulations.

Our key findings were:

- Practice policies were available but staff had no awareness of the policies. For example, the adult safeguarding policy.
- Risks to patients were not appropriately assessed or managed. For example, we found patients being prescribed large quantities of inhalers for the treatment of respiratory disease but there was a lack of monitoring or follow up for these patients whose condition could put them at serious risk of harm.
- There service did not follow current evidence based guidelines and standards.
- There was no formal programme in place for quality improvement, for example clinical audits, to assess the service provision including organisational learning from significant events.
- The service did not have a business continuity plan in place to deal with disruption to the service or staff absence.

Summary of findings

- The provider was aware of and complied with the requirements of the Duty of Candour.
- We found that the service was not following their own recruitment policy which stated that all new employees would receive a Disclosure and Barring Service (DBS) check, but we found that some DBS checks were carried over from previous employment.
- We found that there was no system in place to monitor training, and some staff had not completed training relevant to their role.
- Some patients were not treated in line with best practice guidance.
- Information about services and how to complain was available.
- The service encouraged and acted on feedback from both patients and staff.
- Systems were in place to protect personal information about patients. The service was registered with the Information Commissioner's Office.

The areas where the provider must make improvements are:

- Ensure there are robust governance arrangements in place that includes a programme of quality improvement and that practice policies, such as the recruitment policy, are followed.
- Ensure that questionnaires completed by the patient are fully assessed.
- Ensure there is a system in place for receiving and acting upon medical and patient safety alerts.
- Ensure that patient records are complete and accurate and that care and treatment is delivered in accordance with evidence based guidelines.
- Ensure consent and capacity is adequately assessed, and the identity of a patient is confirmed to ensure the people receiving the medicines are over the age of 18.
- Ensure medical indemnity is in place for clinicians working for the service.
- The service must have a system in place to manage medical emergencies should they arise while a patient is accessing the service.
- Ensure all staff have completed safeguarding training.

The areas where the provider should make improvements are:

- Consider documenting team meetings to ensure learning is disseminated.
- Only supply unlicensed medicines against valid special clinical needs of an individual patient where there is no suitable licensed medicine available

We have suspended the registration of this provider for six month until 29 June 2017 in order to protect patients.

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

- There was a system in place for assessing a patient's identity but this was not effective. Prescribing and analysing patient questionnaires were not consistently monitored and there was no system in place for clinical peer review or support.
- The clinician had received safeguarding training relevant to their role, but non clinical staff had not completed any safeguarding training.
- We found examples of unsafe care where national guidance had not been followed. Patients were being prescribed medicines that required follow up and regular monitoring, which was not happening.
- There were systems in place to protect all patient information and ensure records were stored securely. The service was registered with the Information Commissioner's Office.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, there was no system in place to confirm patients' medical history and previous prescribing decisions for prescribing medicines, and no system for managing medical safety alerts.
- There was no process in place for managing emergencies, should they develop while a patient was accessing the service.

Are services effective?

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

- The service had ineffective systems in place to verify a patient identity. This meant that there was a risk to minors accessing medicines and decisions could be made on false information.
- Consent to care and treatment was not sought in line with the Mental Capacity Act 2005, there was no provider policy relating to capacity and consent.
- We were told that each GP assessed patients' needs but there was evidence that care was not in line with relevant and current evidence based guidance and standards, such as the National Institute for Health and Care Excellence (NICE) best practice guidelines. We reviewed a sample of anonymised patient records that demonstrated inconsistent record keeping.
- The service did not have arrangements in place to coordinate care and share information appropriately.
- If the provider could not respond with the patient's request, this was not adequately explained to the patient but a refund was issued.
- There were induction, and appraisal arrangements in place for staff but not all staff had received training relevant to their role. For example, some non-clinical staff had not received any safeguarding training.

Are services caring?

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

- Systems were in place to ensure that all patient information was stored and kept confidential.
- We did not speak to patients directly on the days of the inspection but we did review feedback data left on Feefo (an online feedback website) which showed that patients responded positively to the service.

Are services responsive to people's needs?

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

Summary of findings

- There was information available to patients to demonstrate how the service operated.
- Patients registered on the provider's website could access a variety of medicines by completing a questionnaire designed to assist the GP in making a decision if a prescription should be issued. Patients could also access other medicines not listed on the website by entering in a 'free chat' system with the GP. The website was accessible 24 hours a day.
- Patients could access a brief description of the clinicians available but at the time of the inspection, there was only one clinician working at the service.

Are services well-led?

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

- The provider told us they had a clear vision to provide an accessible and responsive service. However, our inspection found that systems and processes to govern activity were not effective.
- During the inspection the provider of the service failed to demonstrate they had the experience, capacity and capability to run the service and ensure high quality care.
- Practice policies were available but staff had no awareness that they existed.
- There was no formal system in place for quality improvement of the service. For example, clinical audit.
- Staff told us that team meetings took place but as they were not minuted we were unable to find evidence of this.
- There was a management structure in place and the staff we spoke with understood their responsibilities.
- The service encouraged patient feedback. There was evidence that staff would respond directly to feedback left by patients.

Doctor Matt Ltd

Detailed findings

Background to this inspection

Background

Doctor Matt ltd is an online service that allows patients to request prescriptions through a website which can be dispensed by the affiliated registered pharmacy. Patients are able to register with the website www.doctormatt.co.uk or www.theonlinesurgery.co.uk, select a condition they would like treatment for and complete a health questionnaire which is then analysed by a clinician and a prescription is issued. In the last 12 months approximately 6700 prescriptions had been issued.

Alternatively, patients can request what the provider called a 'bespoke' prescription which could be for any medicine. The prescriber could use a webchat facility to request any further information they needed in order to decide whether to prescribe. Once the prescription has been issued, the medicine is dispensed by an affiliated pharmacy which is part of the same organisation and posted out to the patient by a third party courier service. Doctor Matt ltd can also offer home kit blood testing for certain conditions such as diabetes and anaemia.

Dr Matt ltd is owned by DMC Medical which is a Clinical Service Holding Company. Dr Matt only provides services to patients based in the UK.

Doctor Matt ltd employs a GMC registered GP who works remotely in analysing patient information forms when they apply online for prescriptions. The service also employs a customer service administrator and an IT systems manager. The service can be accessed 24 hours a day, seven days a week through a website but patient information forms are processed Monday to Friday from 9am to 5pm. This is not an emergency service.

A registered manager is 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).

We conducted our inspection on 10 January 2017 when we visited Doctor Matt's registered location in Daisy Business Park, London. We spoke with the registered manager who was also the lead clinician, the IT systems manager and the customer service administrator.

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser, a second CQC inspector, a member of the CQC medicines team, and a further specialist advisor.

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

During our visits we:

- Spoke with a range of staff
- Reviewed organisational documents.
- Reviewed a random 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?

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.

Detailed findings

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

Are services safe?

Our findings

Safety and Security of Patient Information

The provider made it clear to patients what the limitations of the service were. The service was not intended for use as an emergency service.

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.

On registering with the service, and at each request for a prescription, patient identity was not verified and there were no protocols in place to support staff to undertake this function. We found examples of the person paying for the service being different to the patient and there were examples of the billing and shipping address not matching. The GPs had access to the patient's previous records held by the service but did not regularly encourage consent from patients to gain access to medical records held by other services. For example, the patient's regular GP practice. This put patients at risk of harm as it meant that patients were responsible for entering accurate and truthful information about their medical history. The service did not treat children. However, there was no system in place to ensure the provider that children could not access the service.

Prescribing safety

We asked how the provider ensured that they followed current prescribing guidelines. The clinician told us that the questionnaires on the websites were set up in line with best practice guidance, for example National Institute for Health and Care Excellence (NICE) guidance. However not all prescriptions were issued as a result of a structured questionnaire and for these 'bespoke' prescriptions the prescriber did not have an agreed list of medicines which had been assessed as safe for remote prescribing, or a prescribing policy to guide safe prescribing. There were no prescribing audits to monitor the quality of prescribing for either the on-line questionnaires or the 'bespoke' prescriptions,

The provider prescribed antibiotics for a range of conditions. When more than one option was available the online ordering process required the patient to select the antibiotic, the dose and the duration of treatment. The provider did not follow the principles of antibiotic stewardship as they did not consider local or national guidelines.

The provider issued prescriptions for long term conditions, based on information supplied by the patient to show that they had previously been prescribed the medicine. These prescriptions included medicines for diabetes, heart disease and asthma, all conditions which require regular monitoring. We saw examples of requests for prescriptions which were refused because the patient was unable to provide evidence of a blood test for low thyroid activity.

We looked at a sample of patient records and prescriptions, and found discrepancies between them. The clinician told us that if an error was noticed, the prescription would be corrected but the records may not be. They also said that if the dispensing pharmacy raised a query the records would not be updated to reflect any changes made. This meant that if a patient contacted the service again, the prescriber dealing with the request may not have accurate information about previous consultations.

We noted that the provider prescribed unlicensed medicines (medicines are given licences after trials have shown they are effective and safe for use in treating a particular disease. If a medicine is used in a way that is different from that described in its licence, this is called 'unlicensed'use. Treating patients with medicines for a disease that is not described in its license is higher risk because doctors and patients both need to be aware that the drug is being prescribed off license. This means that the drug will not have been through the same process for a drug that is prescribed on license and also will not have the same safety monitoring carried out. There needs to be a dialogue between clinician and patient so that the patient understands any potential risks involved in off label prescribing. Patients also need to be aware that the patient information leaflet inside the packet will not relate to their condition.

Management and learning from safety incidents and alerts

There was no formalised policy for documenting and investigating incidents relating to the safety of patients. We reviewed two significant events that occurred in the past

Are services safe?

year. Staff told us that incidents were discussed during team meetings but there was no evidence to demonstrate that learning was disseminated to staff as meetings were undocumented.

We asked how patient safety alerts were dealt with such as those issued by the Medicines and Healthcare products Regulatory Agency (MHRA), and were told that they were the responsibility of individual doctors. The clinician told us that they did respond to alerts and gave the example that they stopped prescribing antibiotics for gonorrhoea following guidance from the Chief Medical Officer in December 2015. However there was no process within the organisation to receive record, distribute and monitor safety alerts which meant that the provider had no oversight of patients who may have been prescribed medicines which were the subject of these alerts.

Safeguarding

The clinician in the service had received level three child safeguarding training and adult safeguarding training. Non clinical staff had not received any safeguarding training but did have an awareness of what safeguarding meant and they told us they would report any concerns to their manager. There was a safeguarding policy available for staff to refer to, but staff we spoke to did not have an awareness that a policy existed.

The clinician had received training about the Mental Capacity Act 2005 but had not given any consideration to the application of capacity within the service that was offered.

Staffing and Recruitment

The service employed a single clinician and two non-clinical members of staff. We were informed that there was an intention to recruit another clinician.

The provider had a policy in place for the recruitment of all staff, and staff recruitment files were available which contained information such as proof of identification, references and employment history. The recruitment policy stated that recruitment checks would be carried out for all staff such as ensuring medical indemnity was in place and performing a Disclosure and Barring Service (DBS) check prior to commencing employment. (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). However, we found that medical indemnity was not verified for a previously employed clinician and we found that a DBS check was carried over from previous employment. Evidence that the clinician currently working in the service had medical indemnity was provided, but it did not cover working for the Doctor Matt service.

Monitoring health & safety and responding to risks

The provider headquarters was located within a modern, purpose-built office but all staff working for Doctor Matt Ltd worked remotely. Patients were not treated on the premises and GPs carried out the analysis of patient questionnaires remotely usually from their home.

The provider expected that all clinicians would conduct analysis of patient questionnaires in private and maintain the patient's confidentiality. Each GP used their computer to log into the operating system, which was a secure programme.

Due to the nature of the service provided, no medical equipment was required to carry out the regulated activity.

The service did not have a policy in place to monitor and manage risks to patients and there was no business continuity plan in place to deal with major incidents such as a loss of IT systems or staff absence.

Are services effective?

(for example, treatment is effective)

Our findings

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 with further supporting information. The website had a set of terms and conditions and details on how the patient could contact them with any enquiries. Information about the cost of using the service and medicines was known in advance and paid for before the patient accessed the questionnaire.

The service did not have any policies in place to assist in assessing capacity and consent. We reviewed patient questionnaires and we found examples of patients providing contradictory answers to questions, incomplete answers to questions and insufficient information provided to answer questions, but there had been no probing by the clinician undertaking the assessment to clarify information given by the patient.

Staff and the clinician we spoke with believed that the fact a patient was able to complete an on-line form was sufficient to evidence their capacity to make decisions about their care. The service had an ineffective system in place to assess the consent of patients using the service and there was no means of highlighting vulnerable people on the system.

Assessment and treatment

We found that some care was not being delivered in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. For example, in relation to asthma, we found an example of a patient requesting an inhaler with no previous GP assessment of their condition to determine asthma as a diagnosis. The quantities and dosage prescribed for patient use of this medication was an excessive amount. We were told by the clinician that requests for prescriptions for unusually large quantities of medicines would be picked up by the pharmacy, rather than within the provider organisation, and there was no record of communication from the pharmacy in the patient record so the prescriber would not have that information available when dealing with subsequent requests.

Patients completed an online form which included their past medical history, symptoms and any medication they were currently taking. There was a set template to complete for the prescription request that included the reasons for the request and the outcome to be manually recorded on the patient record, along with any notes about past medical history and diagnosis. Patients would also be responsible for selecting what dose of medication they required which should be the responsibility of the clinician. We reviewed 25 anonymised medical records which demonstrated notes had not been adequately completed. Record keeping was inconsistent and not all patient information gathered was attached to the patient record. We also found that all 25 completed online questionnaires had each been analysed by the GP in less than one minute and found that one had been analysed in 17 seconds.

There were examples of patients needing further assessment and not being referred to the appropriate service. For example, a patient had symptoms of rectal bleeding and weight loss, which could signify significant underlying disease, but no guidance was given to seek urgent medical advice. We were however, provided with examples of the provider declining requests for medicines where the patient was unable to provide a blood test result confirming the diagnosis of the related condition. Some requests would be declined without offering an explanation or further advice.

The service did not monitor the analysis of patient questionnaires, or carry out prescribing audits to improve patient outcomes. There was no formal programme in place for quality improvement for example, clinical audits to assess the service provision.

The clinician told us that each prescription was reviewed individually but that they did not audit their prescribing patterns overall. This means that the provider did not undertake a systematic review of prescribing against best practice standards and did not have a process for identifying improvements.

The provider did not monitor the quality of the dispensing and delivery services provided by the affiliated pharmacy, although the services were offered via their websites in combination with the prescription service and there was a single charge covering the whole process.

Coordinating patient care and information sharing

Are services effective?

(for example, treatment is effective)

The provider did not share information with the patient's NHS GP with whom they were registered, and we saw that there was no option on the registration or order forms for patients to consent to the information being shared. The doctor we spoke with was not aware of this, and thought that a copy of the prescription was automatically sent to the patient's GP.

The service offered a range of home blood testing kits which would be posted out to the patient and returned to an independent lab for processing. The results would be sent to the patient and the patient could then request interpretation of the result from the clinician at Doctor Matt. Any abnormal results would be reviewed by non-clinical staff at DMC Medical and then forwarded to clinicians at Doctor Matt to take action but we saw no evidence that this had happened. There was no protocol in place to support the non-clinical staff in performing this role or to ensure all results were reviewed and signed off.

Supporting patients to live healthier lives

We were told by the provider that the role of Doctor Matt was not to support people to lead healthier lives other than treating for obesity or to assist people to stop smoking. The Doctor Matt website contained blogs with information on healthy lifestyle advice on various medical conditions.

Staff training

All staff had to complete induction training which consisted of learning how to use the online system. The service did not keep a record of what training staff had completed. We were provided with evidence that new clinicians employed by the service would have their first online patient questionnaire reviewed and feedback was given on each one.

Administration staff received performance reviews. There was an ineffective system in place for performance monitoring and appraisal for clinicians. We found that some non clinical staff had not completed any safeguarding training.

Are services caring?

Our findings

Compassion, dignity and respect

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

We did not speak to patients directly as part of the inspection but we did review online survey information that was available which showed that patients responded positively to the service. The latest survey information available from Feefo (an online customer feedback service) showed a customer experience rating of 4.7 stars out of five which was based on 364 ratings over the past year. Patients would receive a response from a member of the customer service's team if they left a rating of four stars or less. The majority of patients were happy with the service and delivery of the medicines.

Involvement in decisions about care and treatment

Patient information guides about how to use the service were available. There was a dedicated team to respond to any enquiries and patients had access to information about the clinician available.

Information on the provider's website informed patients about each medicine that was on offer and what might be the suitable dose for the condition it was intended for and pricing for a prescription request was clearly displayed on the website. However, this did not apply to the prescribing of unlicensed medicines as no clear information was given to the patient that the medicine prescribed was unlicensed and the potential risks involved.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

Patients accessed the service via the website from their computer or other portable device with internet access. Patients could complete an online questionnaire for a particular condition or they could enter into a free text chat function with a GP to request medicine that was not listed on the service's website. Patients could access the website 24 hours a day. This was not an emergency service. Prescriptions were dispensed by the affiliated pharmacy only; patients were not able to choose where to get them dispensed.

Tackling inequity and promoting equality

The provider offered the service to anyone who requested and paid the appropriate fee, and did not discriminate against any client group. Patients could access a description of the clinician available. The provider did not offer any translation services for patients whose first language was not English.

Managing complaints

Information about how to make a complaint was available on the service's web site but the provider did not have a complaints policy and procedure. The customer service team member would respond to patients that had any complaints or concerns. The provider was able to demonstrate that the complaints we reviewed were handled correctly and patients received a satisfactory response.

Are services well-led?

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

Our findings

Business Strategy and Governance arrangements

The provider told us they had a clear vision to provide an accessible and responsive service. However, our inspection found that systems and processes to govern activity were not effective.

There was a clear staffing structure and staff were aware of their own roles and responsibilities. There was a range of service-specific policies which were available to all staff but staff employed by Doctor Matt did not have an awareness that policies existed. For example, the safeguarding policy.

There was no formalised procedure in place to monitor the performance or quality of the service and there was no system in place for peer review. The only checks of completed patient questionnaires that were in place were for new clinicians during their probation period.

Care and treatment records were inconsistent and incomplete which went unnoticed as there was no system in place for audits of clinican records or peer review.

Leadership, values and culture

During the inspection the provider of the service failed to demonstrate they had the experience, capacity and capability to run the service and ensure high quality care due to the shortfalls we found during the inspection.

Seeking and acting on feedback from patients and staff

Patients could rate the service using Feefo and there was a policy in place for customer service staff to monitor the feedback and provide a response. Patients could also email the service directly to ask questions or raise a concern and the email address was clearly displayed on the website.

Continuous Improvement

All staff were involved in discussions about how to run and develop the service and we saw evidence of staff being involved in discussion on how to improve the medical questionnaire templates. Staff also told us they felt they could raise concerns.

The service did not undertake any quality and improvement activity such as audits.