DrThom / LloydsPharmacy Online Doctor

Inspection report

Mezzanine Floor
50-54 Wigmore Street
London
W1U 2AU
Tel: 02079899888
www.onlinedoctor.lloydspharmacy.com

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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?	Outstanding

Overall summary

Letter from the Chief Inspector of General Practice

We rated this service as Good **overall.**

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? – Outstanding

We previously inspectedDrThom/LloydsPharmacy Online Doctorin May 2017. The full comprehensive reports for these inspections can be found by selecting the 'all services' link for on our website atDrThom/ LloydsPharmacy Online Doctor.

We carried out an announced comprehensive inspection at DrThom/LloydsPharmacy Online Doctor on 17 September 2019 as part of our inspection programme and to provide a quality rating.

DrThom/LloydsPharmacy Online Doctor are an online (digital) GP service that offers a range of general medical services that include postal testing, remote treatment and remote advice. The service can be accessed through their website, onlinedoctor.lloydspharmacy.com. This is a fee-based service and is available only for patients in the UK. We inspected the online service known as Dr Thom/ LloydsPharmacy Online Doctor, we did not inspect the provider's affiliated pharmacies which are based throughout England.

At this inspection we found:

- The senior management team demonstrated they were a driving force dedicated to delivering the mission of the service. All staff we spoke to felt valued by the leaders and said there was a high level of staff support, engagement and development.
- Patients safety was their priority. The service had good systems to manage risk so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes.
- The service routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Patients could access care and treatment from the service within an appropriate timescale for their needs.
- There was a strong focus on continuous learning and improvement at all levels of the organisation. They effectively used the skills and abilities of their staff team to provide innovative and accessible care, treatment and support to their patients.
- The service had comprehensive business development strategy and quality improvement plan that effectively monitored the service provided to assure safety and patient satisfaction.
- There was a commitment and appetite to work with external partners including the NHS and the third sector to share learning and make the service as accessible as possible.

We saw the following areas of outstanding practice:

- There was a Get-Grow-Keep' strategy where they developed staff skills, competence and knowledge and encouraged staff development opportunities linked to the strategy. They had sponsored one of their GPs to receive training to develop an algorithm to ensure advice and information is given in digestible bite sized chunks throughout the interactive consultation as well as the information being saved in the patient record for later reference.
- The provider demonstrated commitment to system-wide collaboration and leadership. The provider was part of the Sexual Health London (SHL) joint commissioning model, which included an NHS Trust and an integrated diagnostic company who provided remote/self-sampling sexual health services. This has allowed them to improve the process of follow-up and referring patients back to NHS clinics. This is the first collaborative commissioning model of its kind across London and in UK as a whole.
- The provider held quarterly external education activities for GPs free of charge. The most recent education session covered Digital health – the changing face of medicine, Heart Rhythm Disorders and Women's Health Update. These are usually attended by 30 - 40 GPs.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

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

Background to DrThom / LloydsPharmacy Online Doctor

Background

Dr Thoms/Lloyds Pharmacy Online Doctor provides online (digital) GP service which includes consultation with a GP. The service was set up by Expert Health Limited in 2002 and was one of the world's first online health providers.

The service can be accessed through their website, onlinedoctor.lloydspharmacy.com where patients can can free assessments and/or request consultations or medications that require consultation questionnaires to be completed. The service is available only for patients in the UK. If orders are placed between 9am and 6pm on a weekday, the clinical team will aim to assess it and respond to the patient within one hour. Orders placed after 6pm will be processed the next morning, whilst orders placed at weekends or bank holidays between 9am and 6pm will take longer to assess but should be processed within a few hours. Medicine orders cannot be placed over the phone, but a phone line is available to answer queries Monday to Friday 8am to 6pm, Saturday 9am to 6pm. The provider prescribed to 274,517 patients between September 2018 and August 2019.

This is not an emergency service. Patients do not have to pay to register with the service. Subscribers to the service pay for their medicines when making their on-line application. Once approved by the prescriber, medicines prescribed via the Lloyds Pharmacy Online Doctor website can be collected from one of the 1,800 affiliated pharmacies or they can be dispensed, packed and posted by a tracked and secure courier service.

The service is led by a managing director and medical director who are supported by; 8 GPs, both male and female, 5 of whom are salaried and 3 contracted, a clinical education lead, a clinical manager, director of medical research, clinical lead for transformation and innovation, director of medical technology, clinical lead for sexual health and quality, three independant prescribing pharmacists, a compliance and quality manager, Clinical Governance & Regulatory Compliance Officer as well as patients advisory team and an administrative team. GPs carried out the online consultations remotely usually from the providers offices but sometimes at their home.

Dr Thoms/Lloyds Pharmacy Online Doctor 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

Before the inspection we gathered and reviewed information from the provider. During this inspection we spoke to the Registered Manager and members of the management, support 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.

Good

Are services safe?

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. This included a link to area specific safeguarding contacts. All the GPs had received adult and level three child safeguarding training. It was a requirement for the GPs registering with the service to provide evidence of up to date safeguarding training certification.

The service did not treat children, however they had protocols in place to ensure where they were contacted by a young person in relation to sexual health issues the provider would signpost to the most appropriate face to face care setting. We found evidence that demonstrated appropriate safeguarding referrals had been made in relation to three cases

Monitoring health & safety and responding to risks

The supporting team carried out a variety of checks either daily or weekly. These were recorded and formed part of a clinical team weekly report which was discussed at weekly clinical meetings.

The provider headquarters was located within modern offices which housed the IT system and a range of administration staff. Patients were not treated on the premises although some GPs used it as a base to carry out their online consultations. All staff based in the premises had received training in health and safety including fire safety.

The provider expected that all GPs 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 who worked from home 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 and for managing test results and referrals. The service was not intended for use by patients with either long term conditions or as an emergency service. In the event an emergency did occur, the provider had systems in place to ensure the location of the patient at the beginning of the consultation was known, so emergency services could be called.

All clinical consultations were rated by the GPs for risk. If the GP thought there may be serious mental or physical issues that required further attention. Consultation records could not be completed without risk rating. Those rated at a higher risk or immediate risk was reviewed with the help of the clinical support team and safeguarding lead or medical director. All risk ratings were discussed at weekly clinical meetings. 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 where some of these topics had been discussed, for example, a significant incident and a reminder about assessing risk factors in line with national guidance.

Staffing and Recruitment

There were enough staff, including GPs, to meet the demands for the service and there was a rota for the GPs. There was a support team available to the GPs during consultations and a separate IT team. Some of the prescribing doctors were salaried and some paid on a sessional basis/per consultation.

The provider had a selection and recruitment process in place for all staff. There were a number of checks that were 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 registered with the General Medical Council (GMC), on the GP register with a license to practice. They had to provide an up to date appraisal and certificates relating to their qualification and training in safeguarding and the Mental Capacity Act. The service provided indemnity cover for the consulting GPs that covered the scope of their practice.

Newly recruited GPs were supported during their induction period and an induction plan was in place to ensure all processes had been covered. We were told that GPs did not start consulting with patients until they had successfully completed several test scenario consultations.

Good

Are services safe?

We reviewed five recruitment files which showed the necessary documentation was available. The GPs could not be registered to start any consultations until these checks and induction training had been completed. The provider kept records for all staff including the GPs and there was a system in place that flagged up when any documentation was due for renewal such as their professional registration.

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 prescribed, the GPs could issue a private prescription to patients. The GPs could only prescribe from a set list of medicines which the provider had risk-assessed. There were no controlled drugs on this list.

Once the GP prescribed the medicine and dosage of choice, 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.

The provider would prescribe up to 6 months repeat prescriptions as a maximum for erectile dysfunction and hair loss medicine. Following this period, another medicines review would be undertaken before issuing another prescription in accordance with medical history and the number of previous requests. A change in answers or high frequency of requests is flagged up to prescriber before prescribing, so that it can be investigated. We saw evidence on the day of a case where too many requests for an oral contraceptive led to a refusal of supply appropriately. This ensured patients were kept safe from potential risk.

The service prescribed some unlicensed medicines, and medicines for unlicensed indications, for example medicines for premature ejaculation' or medicines used in the treatment of jet lag. (Medicines are given licences after trials have shown they are safe and effective for treating a particular condition. Use of a medicine for a different medical condition that is listed on their licence is called unlicensed use and is a higher risk because less information is available about the benefits and potential risks). There was clear information on the consultation form to explain that the medicines were being used outside of their licence, and the patient had to acknowledge that they understood this information. Additional written information to guide the patient when and how to use these medicines safely was supplied with the medicine.

Dr Thoms/Lloyds Pharmacy Online Doctor provided over 250 thousand prescriptions in the last year. They had developed a new algorithm system which helps to identify false requests for medicines. This is done by an iterative process during the patient consultation/questionnaire. We saw a demonstration of how this works during our inspection.

There were protocols in place for identifying and verifying the patient and General Medical Council guidance, or similar, was followed. The service used electronic prescriptions which were sent to an affiliated pharmacy for them to dispense.

The service had a system in place to assure themselves of the quality of the dispensing process. There were systems in place to ensure that the correct person received the correct medicine.

Information to deliver safe care and treatment

On registering with the service, and at each contact patient identity was verified. The GPs 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 three incidents and found that these had been fully investigated, discussed and as a result action taken in the form of a change in processes. For example, the provider found that approximately 3000 GP notification letters were not sent to respective GPs during a four-month period. The work to fix the issue was carried straight away and a full investigation was carried out by the Operations team. The provider implemented a new process for sending out these letters which involved a third party and meant that GP letters would be automatically converted to PDF files and submitted via a secure online portal. Each letter would have a unique code. They found this reduced the likelihood of any errors and allowed them to track each individual

Good

Are services safe?

letter. The solution had a NHS Information Governance Toolkit Accreditation Level 2. The incident was discussed in a meeting that was attended by representatives from each team to ensure any learning was shared.

The provider carried out six monthly analysis of significant events to identify any trends.

We saw evidence from six 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.

The provider had systems in place to comply with medicines and safety alerts such as those received from the Medicines and Healthcare products Regulatory Services (MHRA).

Good

Are services effective?

Assessment and treatment

The provider used a range of online tools that they provided free of charge to assist their assessment of patient needs. People who used this assessment were not under an obligation to purchase treatment. The provider told us that they felt it helped patients make informed decisions about the safest and most effective treatment.

We reviewed ten examples of medical records that demonstrated that each 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. For example, in relation to contraception patients were supported to make informed treatment choices at various stages of their journey through their service. Patients were guided to choose the right contraception before requesting treatment by completing the 'help me choose a treatment' questionnaire, and patients who requested contraception that was not clinically recommended were signposted to a more appropriate contraceptive choice. Which meant in the last year, more than 1 in 4 patients were declined combined hormonal contraception and signposted to a more appropriate form of contraception. Therefore, by following national clinical guidelines, over 34% of patients who were declined the combined contraceptive in the last 6 months, were successfully switched to a progesterone only contraceptive. The provider told us that in the last year alone, this has ensured that nearly 2,000 patients had been switched to a safer contraceptive.

The provider told us their free assessment for contraception, 'help me choose a treatment' was created in recognition of patients requiring a holistic assessment when delivering care. Since its launch on in September 2019, it has been completed 7,040 times. This technology is one of several free assessments across our service that uses evidence-based guidelines to help patients make informed choices about the safest and most effective treatment option for them.'

The provider also followed the Faculty of Sexual Reproductive Health (FSRH) guidance. The Director of Medical Research also sits on the panel to help create evidence-based guidance to ensure the needs of patients who use digital services are represented.

We were told that where telephone consultation took place they lasted as long as the clinician and patient deem necessary. If the GP had not reached a satisfactory conclusion there was a system in place where they could contact the patient again.

Patients completed an online form which included their past medical history. There was a set template to complete for the consultation that included the reasons for the consultation and the outcome to be manually recorded, along with any notes about past medical history and diagnosis. We reviewed ten anonymised medical records which were complete records. We saw that adequate notes were recorded and the GPs had access to all previous notes.

The GPs providing the service were 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. For example, when they prescribed a combined contraceptive they required patients to attend a pharmacy to get a blood pressure check, height and weight check (to calculate a body mass index or BMI). The pharmacists have to check these before dispensing prescriptions. The provider had evaluated their approach by comparing self-reported measurements from patients to measurements taken in pharmacy. Where concerns in healthcare had been identified all these patients were signposted to appropriate care.

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. Audits of prescribing practice occur monthly of prescribing pharmacist's activity.

The provider developed a remote treatment assessment tool for chlamydia treatment. The provider continued to conduct research in the effective treatment of sexual health. We found that they produced evidence for review that improved care pathways for sexual health and shared it other healthcare providers.

Good

Are services effective?

They were invited to share their findings at the UK's largest scientific conference in sexual and reproductive healthcare in recognition of their contribution to gathering evidence using technologies that are used to support high-quality care.'

Quality improvement

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

- The service used information about patients' outcomes to make improvements.
- Clinical and non-clinical staff (e.g. Patient Advisory and Operations team) are actively engaged in monitoring and improving quality. They had completed 18 clinical audits in the last two years. For example, there was one in relation to sexually transmitted infection (STI) test kits and positive results rates. They looked at what service wide kits patients were ordering and the prevalence of STI's in comparison to the national average. They also reviewed false positive rates for HIV testing as one quarter of test kits requested were for HIV testing. When they re-audited they found the rate of false positive had reduced and they also found demand for kits had reduced. We saw evidence to confirm they communicate 100% of reactive/positive STI test results to patients within 2 working days.
- Where infection or illness that is not treated by this service was identified, the service took steps to contact each patient to conform that they had received care elsewhere. We saw evidence that confirmed that nearly all patients had been contacted within one week and of those spoken to the majority of patients had received care elsewhere
- They have also built in systems to monitor outcomes for patients who are transferred to other services e.g. patients who are transferred to sexual health clinics to receive treatment for gonorrhoea, syphilis or HIV are individually followed up to ensure continuity of care.
- The clinical staff proactively participate in benchmarking and peer review opportunities. This included sitting on influential national committees relevant to their clinical services and digital health e.g. British Association for Sexual Health and HIV (BASHH) Specialist Interest Group in Sexual Dysfunction; FSRH/ BASHH Standard for Online and Remote Providers of Sexual and Reproductive Health Services.
- The providers high performance was recognised by external bodies. For example, they successfully bid for one of the largest NHS digital sexual health contracts. This collaboration involved using intelligence on treatment outcomes from their established private chlamydia treatment service which they had presented at national and international conferences. Outcomes for this service had exceeded expectations and resulted in agreement from commissioners to expand their treatment offer to more patients.
- They have conducted audits to compare their treatment outcomes with other similar services for example, monitoring for overuse of sabutamol in patients using their asthma treatment service and antimicrobial stewardship across all services in the last ten years. While comparative data is scarce, they told us they constantly review available evidence and strive to share their data as much as possible. For example, the provider participates in academic conference presentations.
- The Lead for Clinical Quality oversees audit and champions activities to improve quality and outcomes. This includes actively engaging staff to monitor and improve treatment outcomes e.g. providing mentorship to newer clinical staff to ensure they are trained in how to conduct audit, ensuring all clinical staff conduct an audit at least annually, and ensuring that all quality improvement work is presented at clinical team meetings and if appropriate, to all employees, with a view to engaging with stakeholders to achieve internal audit outcomes as well as organisational objectives.

Staff training

All staff completed a comprehensive training programme which consisted of practical induction, systems and processes, policies, health and safety and information governance. The GPs had to complete specific induction training prior to treating patients, which including mock consultations, peer review and probation review. Staff also completed other training on a regular basis including safeguarding, basic life support and infection control. The Quality and Compliance manager had a training matrix which identified when training was due. An induction log was held in each staff file and signed off when completed.

Good

Are services effective?

The GPs 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 GPs received further online training.

Each team member has an annual appraisal with set development goals. They also have weekly 1:1s include mentoring and were given opportunities for the team member to reflect on their practice and consider opportunities for personal development and career progression. They actively supported the development of their pharmacist independent prescribers. New employees receive a high level of one to one clinical supervision from senior members of the team where all patient consultations are reviewed.

The continuing development of the staff's skills, competence and knowledge was recognised as being integral to ensuring high-quality care. Staff were proactively supported and encouraged to acquire new skills and use their transferable skills. The provider supported senior members of the team to develop their leadership skills and had arranged for an external consultant to conduct a leadership course with follow-up mentoring over several months.

We saw that all staff were also supported and encouraged to develop their own skills and knowledge. For example, GPs and independent prescribers were sent on a Complaints Handling course; a User Experience (UX) course; a Media course; and a Caldicott Guardian training course respectively. They had also sponsored a GP's PhD and an Independent Prescriber's Clinical Diploma.

The provider had systems that promoted sharing best-practice and promoting high-quality care. For example, they had weekly Clinical Team meetings which included non-clinical staff and provided opportunities for peer review, reflection, learning and discussing suggested improvements, e.g. to efficiency; patient journey; service; and clinical risk. They also had a weekly Journal Club for clinicians CPD support and quality improvement activity which included reflective presentations covering domains such as knowledge, skills and performance; safety and quality; and communication, partnership and teamwork. We saw that formats could cover patients' unmet needs and doctor/clinician educational needs; clinical audit findings; case-based discussion with key points referring to literature/journals.

There was a Get-Grow-Keep' strategy where they developed staff skills, competence and knowledge and encouraged staff development opportunities linked to the strategy. Linked to this strategy, they had created an apprenticeship-type role within the company. The scheme allows for the Digital Support Officer to spend 3 months shadowing and learning on the job in each of the following departments: compliance, product, clinical content writing and operations. During each quarter, the apprentice had weekly teaching and mentoring to learn about the role. Following the training year, the apprentice will have the opportunity to choose which more senior permanent role they would like to progress into.

The service continued to develop its staff, and this resulted in many being promoted to positions with more responsibility across the organisation.

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. We saw examples of patients being signposted to more suitable sources of treatment where this information was not available to ensure safe care and treatment. They had signposted more than 45000 patients in the last year.

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

The provider had risk assessed the treatments they offered. They had identified medicines that were 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 open to abuse or misuse, and those for the treatment of long-term conditions such as asthma. Where patients agreed to share their information, we saw evidence of letters sent to their registered GP in line with GMC guidance.

The provider only referred patients to one external service which was for premature ejaculation. Details were completed by the GP who entered the referral information onto the computer system. The patient's advisory team would then use this information to generate a referral letter to the specialist and a copy would be sent to the patient.

The service monitored referrals/follow ups from test results to improve patient outcomes. For example, for patients

diagnosed with gonorrhoea, syphilis or HIV, they actively contacted the patient to transfer care to appropriate services for follow-up and treatment. Newly diagnosed HIV patients are telephoned and followed-up one week later. The providers own key performance indicators showed 100% of test kits for STI's were dispatched within one working day and 97.7% of patients with positive results were confirmed as being referred for treatment within 48 hours of their consultation. This demonstrated a timely response. There was a pathway to follow-up patients that they could not make initial contact with. Their HIV testing guidelines also covered how to give reactive results to patients over the telephone and detailed how to organise transfer of care to local sexual health clinics, for example phoning local clinics before giving test results to confirm when a confirmatory test could be conducted and following up patients after they have had a confirmatory test to ensure completion of care.

Staff, teams and services were committed to working collaboratively and have found innovative and efficient ways to deliver more joined-up care to people who use services. We found the provider took a proactive approach to working with others in the health sector to help improve the overall digital health field, their own service and to provide joined-up care. They worked closely with their partners at Sexual Health London (SHL) which included an NHS Trust and an integrated diagnostic company who provided remote/self-sampling sexual health services, to constantly review the care they were providing in relation to sexually transmitted diseases (STI's).

Further, they were GP members of the FSRH steering group, developing an audit tool to benchmark the standards for emergency contraception prescribing across remote services, primary care and pharmacy. One of their doctors had helped with the development of a template to support effective and safe prescribing and reduce unwarranted variations in care.

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 on the website. For example:

- They are proactive in signposting for smears: they promoted the importance of cervical screening and encouraged patients who were overdue a smear to engage with the National Cervical Screening Programme. For example, they found that since January 2015, 39.4% of patients ordering combined contraception through their service had never had a smear and 5.8% were overdue one. Through their health promotion message and active signposting, they have sent messages out to over 150,000 patients in relation to this in the last 4 years.
- Prescriptions for contraception were only dispensed to patients if their biometrics were within a specified range. We identified evidence that demonstrated medication was only given in appropriate cases. However, the provider recognised patients who were denied medication needed further support. Therefore, patients were given advice on weight loss approaches and signposted to other, more appropriate, support.
- Patients using their STI testing or treatments services were recognised as being at higher risk of having an STI. Therefore patients who used these services received advice to help support them to live healthier lives e.g. how to avoid STIs, advice on HIV, PEP and sexual assault. In the last two years patients placed more than one order for a test kit were targeted and offered advice about how to prevent onward transmission of the STI. They also conducted partner notification for all patients who tested positive for Chlamydia or Trichomoniasis in the last year where permission was given by the patient.
- They promoted external initiatives such as Sexual Health week and smoking cessation by providing patients with advice and appropriate support.
- Between August 2018 and August 2019, they directly asked patients if they had arranged blood testing for diabetes, cholesterol or hormones respectively, where it was recommended in their assessment. They received 11,871 responses within which 4,809 responded 'Yes' representing on average 40.5% of these patients confirming they had further testing elsewhere after using our assessment.
- The provider recognised an opportunity to address an unmet need in their patient population. In January 2015, they established that some patients ordering combined contraception through their service had never had a smear. They reviewed their health promotion material and developed online educational material including six advice pages. The provider targeted patients they identified as at risk by adding information about cervical screening to the information that patients receive when using their contraception and sexual health services.

Good

Are services effective?

- The provider identified how they could improve HPV vaccination uptake and launched an initiative to improve this. Evidence produced during inspection confirmed that this has resulted in many more patients being vaccinated.

In their consultation records we found patients were given advice on healthy living as appropriate.

Good

Are services caring?

Compassion, dignity and respect

We were told that the GPs undertook online/telephone consultations in a private room and were not to be disturbed at any time during their working time. The provider carried out random spot checks to ensure the GPs were 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 and the GP was again reviewed to monitor improvement.

We did not speak to patients directly on the days of the inspection. However, we received more than four hundred 'Share Your experience' forms and all were extremely positive about the service. They also received feedback through their patient participation groups. The results demonstrated that were satisfied or very satisfied and that GPs were polite, made them feel at ease and they were listened to.

Involvement in decisions about care and treatment

Patient information guides 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 clinicians/ GPs working for the service. The GPs available could speak a variety of languages.

The provider sent follow up questionnaires to all patients using their service asking, 'if they were happy with the service' and for any additional comments. The information available from their responses indicated that patients were satisfied with the explanation of their condition.

Good

Are services responsive to people's needs?

Responding to and meeting patients' needs

The service could be accessed through their website 24 hours a day, seven days a week, 52 weeks a year. This service was not an emergency service. Patients who had a medical emergency were advised to ask for immediate medical help via 999 or if appropriate to contact their own GP or NHS 111. If orders were placed between 9am and 6pm on a weekday, the clinical team aimed to assess it and respond to the patient within one hour. Orders placed after 6pm would be processed the next morning, whilst orders placed at weekends or bank holidays between 9am and 6pm would take longer to assess but should be processed within a few hours. Medicine orders could not be placed over the phone but a phone is line was available to answer queries Monday to Friday 8am to 6pm, Saturday 9am to 6pm. Subscribers to the service paid for their medicines when making their on-line application. Once approved by the prescriber, medicines prescribed via the Lloyds Pharmacy Online Doctor website could be collected from one of the 1800 affiliated pharmacies or they can be dispensed, packed and posted by a tracked and secure courier service. The service is available only for patients in the UK.

The provider made it clear to patients what the limitations of the service were.

Patients requested medicines by completing an online questionnaire. If following this the GP required further information, the GP could telephone or arrange a skype consultation with the patient.

Tackling inequity and promoting equality

The provider offered consultations to anyone who requested and prescribed medicines where appropriate, to those who paid the appropriate fee. They did not discriminate against any client group other than those under the age of 18, to whom services were not provided.

Patients could access a brief description of the GPs available. Requests by patients for a GP with a specific gender or who spoke a specific language would be considered on a case by case basis.

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 has been developed and introduced for use. We reviewed the complaint system and noted that comments and complaints made to the service were recorded. We reviewed a summary of complaints from received in the past 12 months and noted they were predominantly been reference to a poor instore experience, such as long pharmacy wait times, stock availability etc. The provider told us they worked closely with the pharmacy network to ensure a smooth journey for patients. They said improvements made had included better oversight of stock availability and increased communications to the pharmacy network regarding changes to their service.

Other formal complaints have been in relation to the clinical rejection criteria, information on the website and clarity around how the service works.

The provider was able to demonstrate that 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.

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 them with any enquiries. Information about the cost of the consultation was known in advance and paid for when an order was placed. The costs of any resulting prescription or medical certificate were handled by the administration team at the headquarters following the consultation. If the GP rejected the request for a medicine the patient was refunded immediately and informed of the decision.

All GPs/staff 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 assessed the patient's capacity and, recorded the outcome of the assessment. The process for seeking consent was monitored through audits of patient records.

Outstanding ☆

Are services well-led?

Business Strategy and Governance arrangements

The provider told us they had a clear vision to work together to provide a high-quality responsive service that put caring and patient safety at its heart. They said they aimed to connect patients with clinicians, as quickly as possible, over every available digital platform. The strategy and supporting objectives and plans are stretching, challenging and innovative, while remaining achievable. We reviewed business plans that covered the next five years and the provider had outlined its objectives to be achieved within the next twelve months which included developing new services in relation to dermatology, continuing to develop the new bespoke algorithm software, expand their service to incorporate video consultations and launch a new website. They also currently consult patients in the Republic of Ireland and intend to increase the number of services they provide there and expand their service to selected countries in the EU over the next five years. They were also intending to start providing consultation and support for self-management of long-term conditions such as COPD, Asthma and diabetes and had recently invested in a small company to research how this could be done safely.

There was also a quality improvement strategy and plan in place and they had identified their current challenges as needing a technology solution in relation to GP letter notification. They said they had a system in place, but they felt it could be further improved and be more streamlined. Also, the patient journey at pharmacy level where their operations department was working collaboratively with Lloyds Pharmacy to develop a solution.

There was a clear organisational structure and staff were aware of their own roles and responsibilities. The leadership team consisted of Managing Director, Head of digital sales and marketing, head of products, chief technical officer, head of operations and medical director. They were supported by a clinical education lead, a clinical manager, director of medical research, clinical lead for transformation and innovation, director of medical technology, clinical lead for sexual health and quality, a compliance and quality manager who between them provided support and advice to staff and platform GPs. The delivery of the online digital service was supported by a whole department dedicated to ensuring the technology, IT infrastructure, digital and information security and was constantly monitored so that threats and issues were mitigated, and support offered to all staff as required.

There was a range of service specific policies which were available to all staff. These were reviewed annually and updated when necessary. Clinical governance and operational governance policies with supporting risk management frameworks and actions plans were established and implemented. There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

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 discussed at weekly clinical meetings which was also attended by representatives from other teams such as operations, products, IT and patients advisory. This ensured a comprehensive understanding of the performance of the service was maintained across all teams and that any learning was shared. The provider also had monthly full team meetings and weekly leadership and compliance meetings and ad-hoc stand-up meetings for things such as product launches.

There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. The provider demonstrated a commitment to risk management systems and processes by continually improving the systems and processes and ensuring staff had the skills and knowledge to use the systems and processes effectively

Care and treatment records were complete, accurate, and securely kept.

Leadership, values and culture

Comprehensive and successful leadership strategies are in place to ensure and sustain delivery and to develop the desired culture. Leaders have a deep understanding of issues, challenges and priorities in their service, and beyond.

The Medical Director had responsibility for any medical issues arising. They attended the service daily. They were supported by the head of operations and a leadership structure for the different departments who formed the senior management team. There was evidence of strong collaboration, team-working and support across all functions to deliver the service's objectives. All staff we spoke to felt valued by the leaders and said there was a high level of staff support and engagement. They were

enthusiastic about their work and had a positive attitude towards the service and its values. They said they felt respected and that there was a genuine 'no blame culture' in the organisation. They also had a process in place for succession planning, their regular discussion at the monthly business meetings in relation to forecasting future skills deficits.

All staff had been involved in developing a clear set of values which were core to their business. These were Integrity, Customer First, Accountability, Respect and Excellence (ICARE). The provider told us this was because patients were their ultimate focus and they always aim to do what's right for the patient. They took personal responsibility for their actions and work. They treated each other and their patients with dignity and consideration and insisted upon quality.

There was a focus on clinical education both internally and externally, continuous improvement by clinical audit and cross collaborative working with external bodies. There was a high level of staff support and engagement through delivering several initiatives such as consultant specialist teaching for their doctors. The most recent one being with a HIV consultant. They had weekly journal clubs, coaching and mentoring for staff at all grades and leadership training.

We were told the provider promoted 'agile' working, which was about continuous self-improvement.

The provider's collaborative working plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership. The provider undertook external education activities which included GP Education sessions held at local venues. We saw the most recent one covered Digital health – the changing face of medicine, Heart Rhythm Disorders and Women's Health Update. These sessions were provided free of charge to GPs.

The service had an open and transparent culture. We were told that 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 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 told us that patients are central to the work and that services are developed with the full participation of those who use them. They said had a range of methods to obtain patient feedback. Patients were emailed at the end of each consultation with a link to a survey they could complete or could also post any comments or suggestions online. They carried out an annual patient's survey where all patients who had used their service in the preceding year would be sent a questionnaire. In the year September 2018 to September 2019 they received 98,000 responses. They also involved patients in the development of new products and services. For example, 18 patients had been involved in testing and providing feedback for their new website which was launched in September 2019. Further, they had emailed the link to provide CQC with feedback prior to this inspection and we received more than four hundred extremely positive responses and comments about the service.

The provider told us that feedback had enabled them to not only create the new patient's accessible website, but also improve their algorithms for a better patient's journey, highlight areas of improvement including the pharmacy network and start discovery and technical work for their new video platform. Patient feedback was published on the service's website.

There was evidence that the GPs 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 Medical Director was the named person for dealing with any issues raised under whistleblowing.

Outstanding ☆

Are services well-led?

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. Staff told us that the team meetings occurred every month where they could raise concerns and discuss areas of improvement. However, as the management team, operations and IT teams worked together there was always ongoing discussions about service provision. We saw from minutes of staff meetings where previous interactions and consultations were discussed.

The provider was involved in a variety of cross collaborative working projects. For example, they worked across twenty-eight CCGs in London and through regular meetings with them and other partners, and patient feedback they had extended their women's sexual health treatments. They said their next step was to provide treatment for sexually transmitted throat infections as well. These modifications to the service reduced the need for certain patients to attend a clinic, therefore improving the burden on the clinic and increasing patient satisfaction.

There was a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of care. The provider was part of the Sexual Health London (SHL) joint commissioning model, where they had regular meetings which had allowed them to improve the process of follow-up and referring patients back to NHS clinics. This is the first collaborative commissioning model across the United Kingdom. They were also a member of a steering group developing guidelines on standards for online and remote providers of sexual and reproductive health services

There was also a strong record of sharing work locally and nationally. The provider had been invited to present work about their service and people's care and treatment outcomes at several international and national academic conferences that were associated with credible external bodies such as the International Union against Sexually Transmitted Infections (IUSTI), British Association for Sexual Health and HIV (BASHH). European Society for Sexual Medicine and King's Fund.

They had given a presentation at the Faculty Sexual Reproductive Health (FSRH) annual scientific meeting in 2018 and had a poster presentation at the King's Fund annual conference for sharing learning and promoting safe remote prescribing practices. They provided clinical advice for the ' ID Verification Standards for Digital Services Provider Input with for CQC Oversight document and were due to present at FSRH "Contraceptive Choices" conference in November 2019.

The provider told us they strove to ensure their digital consultations reflect the most recent national guidelines. They're aim is to provide holistic advice not only restricted to the condition for which the patient is consulting, but also for the patient's general wellbeing. Therefore, advice and information should be given in digestible bite sized chunks throughout the interactive consultation as well as the information being saved in the patient record for later reference. We saw they had sponsored one of their GPs to develop an algorithm to progress this work.