General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: My London Pharmacy, 45 Newman Street, London, W1T 1QE

Pharmacy reference: 9011790

Type of pharmacy: Internet / distance selling

Date of inspection: 24/07/2023

Pharmacy context

This independent pharmacy is situated in a retail premises in central London close to Tottenham Court Road tube station. It mainly supplies private prescriptions for its online prescribing service which people access via its website www.mylondonpharmacy.co.uk. The pharmacy is open to the public and it sells a small range of over-the-counter medicines. It does not offer any NHS funded services.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy effectively manages the risks associated with its services. It has some policies and procedures to make sure the team works safely. The pharmacy undertakes some audits to monitor compliance with procedures and identify emerging risks. And it keeps the records it needs to by law. Team members protect people's private information. And they understand their role in safeguarding vulnerable people, and the pharmacy has additional safeguards in place to make sure treatment is appropriate when supplying medicines online.

Inspector's evidence

The pharmacy's face-to-face services constituted a relatively small part of the business. The focus was the online prescribing service which had been re-established in May 2023 following a suspension of the service in November 2022. The pharmacy offered prescription only medicines (POMs) for range of conditions but it mainly supplied treatments to support weight loss, treatments for sexually transmitted infections and hormone replacement therapy (HRT) for menopausal women. The pharmacy's risk assessments, policies and procedures had been reviewed and updated within the last six months. Several additional safeguards had been introduced for the online services including use of identity (ID) checking services, compulsory video consultations for people requesting weight loss treatments and use of Summary Care Records (SCR) to verify healthcare information.

The superintendent pharmacist (SI) worked as the regular responsible pharmacist (RP). He was the sole director of the company which owned the pharmacy and responsible for the overall management and day-to-day provision of the services. The correct RP notice was displayed identifying the pharmacist on duty. An RP log was maintained but the format meant it could be easily altered which compromised the integrity of the record. The SI agreed to implement a new system to ensure the RP log was a reliable record. The pharmacy had professional indemnity insurance in place and a copy of a current certificate was displayed. The SI confirmed the policy covered provision of online services, including the prescribing service.

The pharmacy's standard operating procedures (SOPs) covered the main tasks and activities and were tailored to the business model. A single team member provided support to the RP on a regular basis working as a dispensing assistant in the pharmacy. They were new to the business, and they had not yet had the opportunity to read and agree the SOPs. But they confirmed they had been given verbal instructions by the SI and that they worked under constant supervision.

The prescribing service was provided by three pharmacist independent prescribers (PIPs) who worked remotely. A GMC registered doctor acted as a clinical advisor. The pharmacy only supplied people based in the UK. The service was not regulated by the Care Quality Commission. The pharmacy had an overarching risk assessment for the online services which covered clinical and operational aspects, such as data protection and communication. It also had prescribing guidelines for each of the conditions being treated which included a risk assessment and an audit template. The guidelines were developed in line with national guidance. PIPs had access to these prescribing guidelines and had signed to confirm they had read them and that they undertook to work within the terms of the guidelines. The SI documented an individualised risk assessment with each PIP which related to their scope of practice and whether they could initiate the various treatments on offer or only re-prescribe after initiation of

therapy.

The pharmacy had an auditing schedule to monitor the prescribing activity against the policies for each condition treated. Each condition had a random sample of ten consultations audited each month and each PIP had their work audited four times per month. The SI discussed the audit findings with the clinical advisor each month, and feedback was provided to each PIP based on their work. An example was when an audit highlighted that a person had stated in the cystitis questionnaire that they could not urinate and had not been explored further by the prescribing PIP. The SI then contacted the person to confirm no adverse effects were experienced, and they clarified that they were able to urinate but found it painful due to the infection. Feedback was provided to the PIP to explore all symptoms which could indicate a different diagnosis. The SI held a clinical meeting once a month where guidelines and audit results were discussed and shared with the prescribers. Minutes of meetings were shared with the team for reference.

The pharmacy's complaints policy was explained on the website. People could contact the pharmacy by email or telephone. The SI managed any issues and concerns by contacting people directly. He liaised with the PIPs if needed. The website provided details of how to escalate a complaint which was not satisfactorily resolved. The pharmacy had systems for recording and reviewing near misses and dispensing errors.

The pharmacy used a recognised patient medication record system to record private prescriptions presented in person. The wrong prescriber had been recorded in some earlier entries but this had since been identified and rectified by the SI. The pharmacy very rarely stocked or supplied controlled drugs (CDs). A couple of CD registers had been created to record the receipt and supply of CDs on private prescriptions a few months previously. The standardised CD prescription forms had not been submitted to the relevant authority for auditing. The SI was aware that this was a requirement and agreed to make sure the forms were submitted, and that an appropriate system would be put in place to make sure this happened in a timely manner in future. The pharmacy had not dispensed any unlicensed (specials) or emergency supplies.

The pharmacy used a bespoke software system for its online services. The system recorded completion of ID checks, the information submitted on online questionnaires, the PIP's consultation/ prescribing notes, details of any interventions and additional communications, the prescription details and the medication supplied. PIPs accessed the system using their individual log-in and could generate electronic prescriptions which contained their unique electronic signature. The pharmacy team downloaded and dispensed prescriptions once they were approved. If requests for medication were refused this information was also recorded. Private prescription records for online supplies were integral to the system and extracts viewed contained the correct information.

The pharmacy was registered with the Information Commissioner's Office. The privacy and cookies policies were available on the website. Confidential waste was collected segregated and disposed of securely. The dispensing assistant confirmed they had been briefed about confidentiality and data protection when they first started working at the pharmacy. The pharmacy used a third-party provider to complete ID checks when people requested medication online. Medicines were not supplied to anyone under 18 years of age and the age was verified by the ID checks. If ID checks failed, the pharmacy contacted people requesting additional information such as photo ID and proof of address. The pharmacy had inbuilt systems to identify people attempting to create duplicate accounts in order to obtain medication. People were required to provide consent for the pharmacy to access their SCR (if they lived in England) and contact their GP when they requested weight loss or asthma medication and HRT. People living in Scotland and Wales who did not have SCRs were asked for their medical history. If the information provided could not be sufficiently verified, the pharmacy contacted the person and

refused to process the order. People were signposted to their GP or a service in their local area.

The SI and PIPs had completed safeguarding training so understood what signs to look for. PIPs had all completed level 3 training. The SI explained the PIPs had occasionally identified people trying to request weight loss medication inappropriately. Evidence of rejected orders was reviewed. For example, an order was rejected due to the person having a lower body mass index (BMI) than the range in the pharmacy's prescribing guideline. Body Mass Index (BMI) was verified using SCR if weight and height was listed and through video consultations. The PIPs used professional judgement to determine if someone was likely to be the BMI reported on the questionnaire. And if in doubt they required the person to weight themselves and show the PIP the reading on the scales. One example provided was when a person who ordered medicines for weight loss wore baggy clothes during the video consultation. This prompted the PIP to seek additional verification of weight. And when none could be provided, they made the decision to reject the order due to potential safety concerns. The pharmacy signposted people who had lower BMIs, but were potentially eligible for treatment, to a registered weight loss clinic for a face-to-face assessment. Another example of how the pharmacy safeguarded vulnerable people was when the team identified that a person who requested medicines for weight loss was prescribed antipsychotics. The pharmacy had communicated with the person's GP to check if the supply was appropriate.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's staff profile and skill mix are suitable for the services it provides. Although some of the team member work remotely, they can communicate with each other easily, and they can seek support or raise concerns if needed. Prescribers are supported to use their professional judgement and they receive feedback about their performance to help them improve.

Inspector's evidence

At the time of the inspection, the SI was working with the dispensing assistant processing website orders in the pharmacy. The pharmacy's IT specialist and website developer was also present making some upgrades to the pharmacy's systems. The team members who worked remotely, could communicate with each other using a workplace messaging system. The pharmacy had access to locum pharmacists who served as the RP when the SI was absent. As the pharmacy had a team of PIPs the workload could be allocated according to their availability. Holidays were planned to make sure the pharmacy had enough staff cover. The pharmacy communicated any anticipated delays to people in advance where possible.

The workload appeared to be manageable. The SI had recruited the trainee dispensing assistant in anticipation of the workload increasing. The dispensing assistant had only worked at the pharmacy for one or two weeks. The SI explained that he would be enrolling them on an accredited course and confirmed he had done this following the inspection.

The PIPs were recruited and inducted by the SI. He completed enhanced Disclosure and Barring checks for all prescribers and reviewed their training portfolios to check they had the correct competencies for the role before hiring them. All prescribers worked in other prescribing roles in addition to the work they did with the pharmacy. They were all based in the UK and were interviewed by the clinical lead before appointment. One of the PIPs who was more experienced acted as the prescribing lead. Prescribers received salaries and were not incentivised financially based on the number of consultations or prescriptions issued. The pharmacy supported PIPs to complete additional training relevant to their roles. One of the PIPs was working on developing further competence in HRT for the management of menopause symptoms in anticipation of extending their prescribing in this area.

The doctor worked in an advisory capacity. He did not work with the pharmacy on a daily basis or actively prescribe. He was available to provide support, and one of the PIPs confirmed they could contact him for advice regarding complicated cases or where they felt additional support was needed. The pharmacy held occasional clinical meetings to discuss any issues or problems that had occurred. For example, a meeting had been called to discuss next steps following a National Patient Safety Alert relating to shortage issues with GLP-1 receptor agonists. Minutes of this meeting were available. Prescribers received individual feedback about their performance through the pharmacy's auditing process. The pharmacy had a whistleblowing policy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and suitable for the current services. But the layout does not provide much privacy for the dispensing operation. And some areas of the pharmacy are cluttered and untidy which detracts from the professional image and the working environment. The pharmacy does not effectively update the content of its websites to make sure they are accurate. This could be confusing or misleading for people accessing the online services.

Inspector's evidence

The pharmacy occupied a small retail unit arranged over two floors. It was suitably secured when closed. The ground floor included a very small retail area, a dispensary and a toilet with handwashing facilities. Stairs led to the basement which was used mainly for storage but there was a small staff kitchen and another toilet. The pharmacy did not have a dedicated consultation room. It offered very few face-to-face services, and a quiet area of the pharmacy could be used for confidential discussions if needed. The dispensary was basically fitted with a small amount of shelving and bench space. A table was used to provide additional workspace and there was a small dispensary sink. Air conditioning controlled the room temperature. The dispensary was open plan, so people visiting the pharmacy could potentially see and overhear the activities taking place. And some areas of the dispensary and basement were cluttered and disorganised.

The pharmacy's website www.mylondonpharmacy.co.uk provided information about the pharmacy. People were transferred directly to a second website www.app.mylondonpharmacy.co.uk to access the prescribing service. Several inconsistencies and minor issues were identified with the content of the websites. For example, the websites included the prescribers' details with links to check their registration, but this information was not easy to find. And the website promoted Ozempic and Rybelsus for weight loss which was outside the scope of their marketing authorisations and misleading. Some of the content was out of date, such as information included in the privacy policy and the complaint procedure. And some references, terminology, discount offerings and explanations of the pharmacy's processes were misleading. When these issues were highlighted, the SI arranged for appropriate changes to be made to the website immediately.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages and delivers its services safely. It provides people with appropriate advice and support. And it makes additional checks before supplying medicines online to make sure they suitable for the person requesting the treatment. The pharmacy communicates relevant information with other healthcare professionals involved in the person's care. It sources and stores medicines appropriately. And it carries out checks to help make sure that medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy usually operated Monday to Friday 10am to 6.30pm and Sunday midday to 6.30pm but the opening hours were flexible. The pharmacy had a manual door at the entrance. Access was reasonably unrestricted, and team members could offer assistance if needed. The website provided details about the location of the pharmacy and included an email address and telephone number. It promoted some treatments or services that were not currently available which could be confusing for people trying to access them. For example, the website suggested people could start a consultation to request medicines for travel sickness and constipation although these services were not offered, and the pharmacy did not supply any over-the-counter (OTC) medicines online.

People created an account linked to an email address when requesting medication via the website. They completed an online questionnaire. This included both general heath and more specific questions related to the medical condition they were requesting treatment for. Questionnaires had been developed in keeping with guidelines and approved by the clinical advisor and PIPs. Completed questionnaires were reviewed by one of the PIPs and a prescription was issued if they felt this was appropriate. Online questionnaires were largely appropriate in content. In particular, the online questionnaire for HRT was comprehensive and asked for detailed information regarding symptoms and medical history. And it asked whether the person had a hysterectomy as this determined the type of HRT they were prescribed. The system flagged when a person had altered the answer to a question and PIPs could contact people to request further information which would be captured in the consultation notes. The PIPs could view a person's profile and ordering history when making their clinical assessment.

Treatments for asthma and HRT were only supplied as ongoing treatments and it was mandatory for people to provide access to their SCR or health record and GP. The SI had SCR access. He checked people's records to verify the information provided and to confirm the person was already receiving treatment. He communicated this information to the PIPs. If a supply was made the pharmacy automatically informed the person's GP.

Treatments for weight loss could be initiated or provided as ongoing treatment. Most of the weight loss medications supplied were GLP-1 receptor agonists including Saxenda, Ozempic, Rybelsus and Trulicity. People provided information on the online questionnaire and were required to book a video consultation with one of the PIPs for further assessment to determine if they were suitable for treatment. Video appointments were scheduled on a dashboard. If people did not attend their request was not progressed. The PIPs documented that a video call had been completed and made a record of the additional information they had obtained or provided as part of their clinical assessment. The SI checked of the person's SCR for red flags or contraindications and informed the PIP of any potential issues. For example, a history of eating disorders, contraindicated medication or more serious mental

health issues. If a prescription was issued the person was sent an email with instructions how to use the medication including links to online videos showing people how to inject themselves and lifestyle information to support weight loss. They were also provided with sharps bins and information about how to dispose of needles. The person's GP was always informed if a supply was made. People receiving treatment were scheduled for a follow up appointment after four weeks. This could be a telephone or video call depending on the individual person. If the PIP felt a video call was required to verify clinical appropriateness, then this was arranged. The follow up consultation explored any adverse effects to the treatment and any questions the person had. Weight was checked before any treatment was re-prescribed.

Following the National Patient Safety Alert relating to stock shortages, the pharmacy had decided not to initiate any new patients on GLP-1 receptor agonists for off licence use to support weight loss. The PIPs were proactively reviewing all people who were receiving this type of treatment, advising them of the situation and offering an alternative weight loss programme. The pharmacy was intending to use its remaining stock to provide three months treatment for existing patients with BMIs over 35 or people diagnosed with or at risk of developing diabetes. The SI confirmed that the pharmacy would not prescribe GLP-1 agonist for off-label for weight loss once existing stock was exhausted, in line with the patient safety alert, and only recommence this once the shortages issues were resolved.

All supplies were clinical checked and approved by the pharmacist. The pharmacist had access to the pharmacy's clinical records linked to each person's account so they could use this information to support their check. Medicines were supplied with patient leaflets and supporting information in the case of medicines prescribed for off-licence use.

Assembled online orders were dispatched using a Royal Mail service which could be tracked by the pharmacy. Fridge items were placed in specialist cold chain packaging which had been validated to maintain the temperature for 48 hours. Delivery was usually completed within 24 hours. Any medicines which were outside cold storage for over 48 hours were returned to the pharmacy and a new supply was issued.

The pharmacy supplied a small range of OTC medicines and covid tests. Sales were supervised by the pharmacist. The pharmacy dispensed less than 10 walk-in prescriptions each week. These were mostly issued by local private doctors or clinics. The pharmacist was aware of the risks of taking valproate and isotretinoin and the need for a pregnancy prevention programme for people who were at risk, although the pharmacy had not supplied either of these medicines.

The pharmacy sourced its medicines from a range of licensed suppliers. Medicines were stored in a reasonably orderly manner on shelves. A date check had been completed a few months previously and expired medicines had been disposed of. No out-of-date medicines were found during a random check. The SI confirmed a pharmaceutical waste contract was in place. The pharmacy did not have any CDs requiring safe custody. The pharmacy received email alerts from the MHRA, and recent examples were seen and had been marked to show they had been actioned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the correct equipment that it needs to provide its services. And it stores its equipment securely.

Inspector's evidence

The team could access the internet and appropriate reference sources. There were two medical fridges for storing medicines. Fridge temperatures were monitored daily. The pharmacy had a small suitably secured CD cabinet.

There were cartons and packaging for assembling and dispatching medicines, including cold packs and insulated materials for refrigerated items. A paper shredder was available. All electrical equipment appeared to be in working order. Computer systems were password protected and each of the team members had their own log-in so any actions were attributable to them. Terminals were positioned so they were not visible from the public area.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.