The Frater Clinic

Inspection report

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

Ratings

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

Overall summary

We carried out an announced comprehensive inspection at The Frater Clinic on 2 July 2018 and 11 July 2018 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

This inspection was an announced comprehensive inspection which we undertook on 2 April 2019 to confirm that the provider had carried out their plan to meet the legal requirements in relation to the issues identified in our previous inspection in July 2018. This report found that the service had made some improvements, however there remained issues that needed to be addressed.

You can find the reports of our previous inspections by selecting the 'all reports' link for The Frater Clinic on our website at www.cqc.org.uk.

The service is registered with the CQC for the regulated activity of treatment of disorder, disease and injury.

This service is rated as Requires improvement **overall.**

At this inspection the key questions are rated as:

Are services safe? – Good

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

The Frater Clinic is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the private medical services it provides. There are some exemptions from regulation by CQC which relate to particular types of service and these are set out in Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Frater Clinic provides corporate health screening and pre-employment screening programmes to some employers. These types of arrangements are exempt by law from CQC regulation. Therefore, we did not inspect these.

The provider is the registered manager. 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. Ten people provided feedback about the service, which was wholly positive.

Our key findings were :

- The service had succeeded in making improvements to most aspects of their policies and protocols, but there were areas for improvement identified.
- The provider had taken steps to implement quality improvement activity but there were areas for improvement identified. Namely, the provider had not sufficiently monitored the activity carried out by the consultants granted practising privileges.
- A review of nine patient records found an instance, when the care provided was not in line with local or national guidance.
- The two audits we reviewed did not demonstrate quality improvement.
- The provider had acquired an electronic recording system to support quality improvement.
- The service had reviewed risks associated with the service's premises and ensured formal safety risk assessments had been carried out.
- The service had maintained a record of fire drills as outlined in their fire risk assessment.
- Employment and training records of the consultants were maintained appropriately.
- Governance arrangements had improved to ensure oversight of risk.
- We did not see documentation of whether a chaperone was offered to patients.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

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

- Review and improve the processes for patients to access a chaperone within the clinic.

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 GP specialist adviser.

Background to The Frater Clinic

The Frater Clinic is based at 94 Harley Street, London, W1G 7HX. The clinic rents three rooms on the ground floor. Several other healthcare services are based in the building, and there is a shared reception, waiting room and toilets. The area is well served by public transport. The clinic provides private general practice (GP) care and travel medicine services (including vaccinations) to adults and children. The majority of the clinic's patients are non-UK residents or residents that travel frequently. Where patients are assessed as needing assessment and treatment by a consultant specialist, the GP refers to either a consultant specialist with practising privileges, who sees the patient at the clinic, or an independent specialist. Patients pay the clinic for both GP and specialist care received at the clinic, and the consultant specialists then invoice the clinic for their payment.

GP care at the clinic includes travel medicine, treatment of short and long term conditions, immunisations and antenatal care. Minor surgery is performed at the clinic by a doctor who is a specialist in dermatology.

The staff team comprises the medical director, who works as a GP and a practice manager. At the time of the previous inspection in July 2018, the clinic granted practising privileges to 47 consultants. At this inspection, we found that the clinic had reduced the number of consultants granted practising privileges to four. The consultants attend the clinic when there is a patient who requires an appointment. The consultant's individual specialties are in cardiology, endocrinology, breast surgery and geriatric and general medicine. The majority of care provided by the clinic is episodic.

Consulting hours are 9.30am -5.30pm, Monday to Friday, for booked appointments only. When the clinic is closed, patients are directed to other services. The clinic's website address is:

We visited The Frater Clinic on 2 April 2019. The team was led by a CQC inspector, accompanied by a GP specialist advisor. Before the inspection, we reviewed notifications received from and about the service, and a standard information questionnaire completed by the service.

During the inspection, we received feedback from people who used the service, interviewed staff, made observations and reviewed documents.

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?

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

Good

Are services safe?

We rated safe as Good because:

At the inspection carried out in July 2018 we found that the provider was not providing safe care in accordance with the regulations, in part, because:

- Some arrangements were in place to keep people safe and safeguarded from abuse, but these were not sufficiently well implemented.
- Recruitment check records were incomplete.
- Arrangements to prevent and control the spread of infections were not sufficiently formulated or implemented to keep patients safe.
- The clinic did not ensure that all equipment used in the clinic was safe and fit for purpose.
- Arrangements for the management of medicines did not ensure that prescribing was always safe and appropriate.
- The clinic's incident reporting policy was not consistent with the requirements of the Duty of Candour.

At this inspection, we found that the majority of safety concerns had been rectified and the service is rated as good for providing safe care.

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- The provider conducted safety risk assessments. It had appropriate safety policies, which had been reviewed and communicated to staff. They outlined clearly who to go to for further guidance. The service had systems to safeguard children and vulnerable adults from abuse.
- All consultants had up to date adult and child safeguarding training to the apporiate levels.
- At the time of inspection, the service did not have a system in place to assure that an adult accompanying a child had parental authority. We discussed this with the provider and were informed that the majority of patients who attend the clinic with a child were long-standing patients who were treated at the clinic during their pregnancies. However, the provider will now require new patients who require a child to be examined at the clinic to provide the passport of the child and parent. The provider forwarded proof the service's safeguarding policy had been updated to reflect this change.
- The provider maintained a record of Disclosure and Barring Service (DBS) checks for the consultants given practising privileges and had created a spreadsheet of their renewal dates. (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).
- Staff who acted as chaperones were trained for the role and had received a DBS check. The provider informed us that chaperones were offered to patients. We did not see evidence that this was documented in patients consultation notes.
- There was an effective system to manage infection prevention and control. The provider had carried out a legionella risk assessment in May 2018.
- The provider had commissioned a new cleaning company since January 2019. A record of daily cleaning for the three clinical rooms had been maintained. Cleaning materials were stored in a locked cupboard. Monthly water temperature checks had been carried out.
- The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste. We saw evidence that the provider had ensured that equipment brought into the clinic had received a portable appliance test.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- The provider understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example, sepsis. The provider maintained a full list of the required emergency medicines at the clinic.
- Resuscitation equipment and emergency medicines were readily available and clinical staff was suitably trained in emergency procedures.
- There were appropriate indemnity arrangements in place to cover all potential liabilities.
- The provider had plans in place and had trained staff for major incidents.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

Good

Are services safe?

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- The service had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they ceased trading.
- Consultants made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

The service had reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, including vaccines, controlled drugs, emergency medicines and equipment minimised risks. The service kept prescription stationery securely and monitored its use.
- The provider had disseminated safety alerts to the consultants granted practising privileges and had updated the clinic's safety alert policy to reflect this requirement.
- We reviewed one cycle of a prescribing audit which was scheduled to be repeated within 12 months. The provider's prescribing policy had been updated to reflect the requirement for annual prescribing audits.
- The clinic carried out daily vaccine refrigerator checks in line with its policy. Temperatures were in range.

Track record on safety and incidents

The service had made improvement to safety processes.

- There were risk assessments in relation to safety issues within the premises such as health and safety and a fire safety risk assessment. The provider had ordered additional fire exit signs to aid staff and first responders in the event of an emergency.
- There was a system for recording and acting on significant events.
- We reviewed one significant event that had occurred at the clinic since the last inspection and found that it was managed satisfactorily.

Lessons learned and improvements made

The service had processes in place to learn from and make improvements when things went wrong.

- There was a system for recording and acting on incidents and significant events.
- The service had a system in place to disseminate safety alerts to all members of the team.

Requires improvement

Are services effective?

We rated effective as Requires improvement because:

At the inspection carried out in July 2018 we found that the provider was not providing effective care in accordance with the regulations because:

- Staff were aware of some current evidence-based guidance. Guidance in the clinic had not been updated to reflect the latest evidence-based guidance.
- There was no recent evidence of improvement in care as a result of clinical quality improvement activities.
- Although we were told that individual clinical staff attended educational events, there was no documented approach to ensuring that those with particular roles had completed updates relevant to their work.
- The files we reviewed had no evidence of appraisal. One appraisal document was sent after the inspection.

At this inspection, we found that the provider had made some improvements; however, there were still areas that required additional improvement. Therefore, the clinic is rated requires improvement for providing effective care.

- There was limited monitoring of the outcomes of care and treatment.
- There was no documented approach to ensure consultants had completed updates relevant to their field of work.

Effective needs assessment, care and treatment

The provider had put some systems in place to keep consultants up to date with current evidence-based practice.

- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical well-being.
- Consultants had enough information to make or confirm a diagnosis.
- We saw no evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

There was limited monitoring of the outcomes of care and treatment.

- We reviewed the clinic's cervical smear adequacy audit which was scheduled to be repeated annually. The audit showed 100% adequacy.
- There was no recent evidence of improvement in patient care resulting from quality improvement activity. We reviewed two audits carried out by the provider in the last year. A study of prostate-specific antigen did not measure activity against any set standards or intended performance. There was no assessment of whether patients with a raised PSA level had received care in line with national or local guidelines.
- The provider carried out an antibiotic prescribing audit, which stated that it was based on NICE guidelines. The guidelines call for an audit of between 20 and 40 consultation records relating to acute sore throats. The provider explained that due to the low number of patients that present at the clinic with sore throats the audit focussed on antibiotic prescribing and referenced one patient that had a sore throat. This audit did not demonstrate quality improvement.
- Evidence from patient records showed that prescribing was not always in line with relevant and current evidence-based guidance and standards. We reviewed the records of nine patients and found that one of the patients was prescribed their medication at intervals of between six and twelve weeks. We discussed this with the provider to find out how they ensured the patient's compliance with the medication and how the patient received medication during the gaps. The provider informed us that the patient was a frequent traveller who maintained concordance with their medication in their home country.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- The provider showed us a 'Conditions for Practising Privileges' form used as part of an integration to the service tool for consultants with practising priveleges. The document included the requirement for consultants to provide evidence of registration with the GMC, requirement to sign the patient confidentiality document, and the requirement to notify the provider if they become infected with a virus or infectious illness.
- We saw evidence of practising qualifications of the four consultants granted practising privileges.

Requires improvement

Are services effective?

- We saw evidence of consultants' attendance at external educational events; two of the consultants had attended training relevant to their roles. There was no documented approach to ensure consultants had completed updates relevant to their field of work.
- All staff were appropriately qualified. The provider had an induction handbook for any new consultants being granted practising privileges.
- Training records confirmed that the consultants that had been granted practising privileges were up to date in safeguarding adults and children, basic life support, infection control, fire safety, health and Safety, information governance and the Mental Capacity Act 2005.
- The clinic maintained a list of the most recent appraisals for the consultants.
- Consultants had received the immunisations appropriate for their role.

Coordinating patient care and information sharing

Staff worked together, and worked well with other organisations, to deliver effective care and treatment.

- Patients received coordinated and person-centred care. Staff referred to and communicated effectively with, other services when appropriate. For example, the clinic's registration form requested the details of patient's NHS GP and asked whether details of their consultation could be shared with their NHS GP. If patients agreed, we were told that a letter was sent to their registered GP. Clinical staff were aware of their responsibilities to share information under specific circumstances (where the patient or other people were at risk).
- When patients saw a specialist doctor at the clinic, the provider would, in the presence of and with the consent of the patient's, facilitate coordinated patient care.
- Patient information was shared appropriately (this included when patients moved to other professional services), and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.

Supporting patients to live healthier lives

Staff were consistent and proactive in empowering patients and supporting them to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice, so they could self-care.
- Health promotion information was available at the clinic and on their website.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support. We reviewed patient notes which included letters to and from the patient's host GP.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance .

- The GP understood and sought patients' consent to care and treatment in line with legislation and guidance.
- We saw evidence that consultants who had been granted practising privileges had received training on the Mental Capacity Act 2005.

Good

Are services caring?

We rated caring as Good because:

Kindness, respect and compassion

All the feedback we saw about patient experience of the service was positive. We made CQC comment cards available for patients to complete two weeks prior to the inspection visit. We received 10 completed comment cards, all of which were positive and indicated that patients were treated with kindness and respect. Comments included that patients felt the service offered was excellent and that staff were caring, professional and treated them with dignity and respect.

Staff treated patients with kindness, respect, and compassion.

- Feedback from patients was positive about the treatment they received at the service. We reviewed a patient survey carried out by the clinic between July 2018 and April 2019. All of the ten respondents stated that they were very satisfied with the clinic overall.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

At the last inspection we reported that the relationship between the consultants granted practising privileges and The Frater Clinic was not made clear to patients so that they could make an informed decision as to their choice of specialist referral. At that time, the clinic's website described these consultants as "our doctors" and "our specialist team". At this inspection, we found that the clinic had updated the website, making it clear that the consultants were not part of the same organisation.

- Interpretation services were available for patients who did not have English as a first language. Patients were also told about the multi-lingual staff who might be able to support them. There was access to a telephone translation service and face-to-face translators if required. There was no hearing loop, but staff told us how they would support patients who had a hearing impairment.
- Patients told us through comment cards, that they felt listened to and supported by staff to make an informed decision about the choice of treatment available to them.
- The service gave patients clear information to help them make informed choices.
- We observed feedback forms for the clinic displayed in the waiting area.
- The initial cost of a GP and specialist consultation were laid out on the clinic's website.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Patient records were securely stored.
- The service had systems in place to facilitate compliance with data protection legislation and best practice.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

Responding to and meeting people's needs

The service organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The clinic was designed to offer quick, easy and efficient access to patients.
- Services were offered on a private, fee-paying basis only and were accessible to people who chose to use it.
- The provider understood the needs of their patients and improved services in response to those needs. The provider informed us that working hours were flexible to accommodate a patient's preferences and availability.
- The facilities and premises were appropriate for the services delivered.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis, and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Referrals and transfers to other services were undertaken in a timely way. We reviewed the clinic's cancer referrals and saw that they were actioned immediately.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded/did not respond to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available in the patient waiting area. Staff treated patients who made complaints compassionately.
- The service informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint.
- The service had a complaint policy and procedures in place and learned lessons from individual concerns, complaints and analysis of trends. It acted as a result to improve the quality of care. For example, the provider had worked with the building's owner to redecorate the communal areas in response to complaints received by patients that the area required revamping.

Requires improvement

Are services well-led?

We rated well-led as requires improvement

At the inspection in July 2018 we found that the service was not providing well-led care in accordance with the relevant regulations because:

- The directors had not recognised and addressed the governance challenges presented by the delivery model adopted.
- There was not an effective system for monitoring the quality of care, in line with the clinical model.
- Directors had not established proper policies, procedures, and activities to ensure safety and assured themselves that they were operating as intended.
- A number of risks were not adequately assessed or mitigated. These had not been identified and rectified by the clinic processes.
- The directors had not established an effective system for monitoring the care and treatment provided by all staff, and by the service as a whole. There was no recent evidence of improvement in care as a result of clinical quality improvement activities.
- There were limited mechanisms for patients to provide written feedback and little evidence that this had been used to make improvements to the quality of services.
- The service had assumed, but did not ensure, that consultants who had been granted practising privileges had up-to-date training and access to the latest alerts and guidance.
- The service had not maintained a copy of appraisals carried out for the consultants awarded practising privileges.
- Meeting minutes did not contain detail of what was discussed and did not contain a record of actions.

At this inspection, we found that these issues had not been fully addressed and the service is rated as Requires improvement for providing well-led services because:

- Leaders did not demonstrate effective oversight of the consultants granted practising privileges.
- There was limited quality improvement activity in relation to the clinical outcomes for patients.
- At the time of inspection there was no evidence of a process in place to follow-up on patients that were referred for secondary care. Following the inspection the provider forwarded proof of five patients whose treatments were follow-up by the service.
- The minutes of meetings attended by the consultants granted practising privileges could not be used as a record that could be referred back to and used for follow-up purposes because they did not capture the detail of the meeting or agreed outcomes.

Leadership capacity and capability;

Leaders aspired to deliver high-quality, sustainable care.

- The provider stated that the service's main challenge centred on the requirements of the building.
- Leaders did not demonstrate effective oversight of the consultants granted practising privileges.
- The clinic had monthly management meetings with other providers in the building, to address common concerns. These meetings were not attended by the consultants granted practising privileges and did not include discussions on quality or sustainability.
- At the inspection carried out in July 2018, we had concerns regarding the leaders addressing the challenges presented by delivering a model that required oversight of 47consultants. At this inspection, we found that the provider had reduced the number of consultants provided practicing privileges to four.
- Leaders were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

Vision and strategy

- The service had a clear vision and credible strategy to deliver high-quality care and promote good outcomes for patients. Nevertheless, improvements were required to develop an effective system to monitor the quality of care.

Culture

The service had made improvements, in developing a culture of high-quality sustainable care.

- We reviewed the recruitment files of consultants provided practising privileges. Recruitment checks were carried out in accordance with regulations and a list of the required training undertaken was maintained.
- The provider had maintained a copy of appraisals for the consultants.

Requires improvement

Are services well-led?

- We reviewed the monthly meetings minutes between October 2018 and March 2019, all contained details of the discussions that had taken place and action points. However, these meetings all related to the running of the premises.
- All policies and procedures had been updated and had a date for review.
- The service focused on the needs of patients.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.

Governance arrangements

The systems in place did not adequately support good governance and management

- Structures, processes, and systems to support good governance and management required additional work to clearly set out the governance and management of joint working arrangements to promote interactive and co-ordinated person-centred care. For example, we reviewed a patient record which showed that in July 2017 a patient was referred to see a cardiologist, that was granted practising privileges by the provider. There was no record of a follow-up by the provider within the patient's notes.
- The provider had developed a policy to retain copies of documents related to consultants with practising privileges.
- All consultant files contained a signed code of ethics and conditions for practising privileges at the clinic.

Managing risks, issues and performance

There was evidence that the provider had managed risks, issues and performance. However, these processes were not embedded into the service.

- There was no evidence of a programme of active audits.
- As part of the provider's pre-inspection information, we received an audit of consultants' consultation notes. The audit contained information referring to areas of improvement and action taken. The audit was undated and did not reference a follow-up date.
- Clinical audits did not demonstrate a positive impact on quality of care and outcomes for patients.
- Leaders had oversight of safety alerts, incidents, and complaints. We saw evidence that patient safety alerts were disseminated to the consultants.

Appropriate and accurate information

In the main, the service acted on appropriate and accurate information. However, there were areas where improvements should be made.

- The service's paper-based record keeping system did not lend towards enabling assessments of medication reviews, repeat prescribing or performance data for the consultants granted practising privileges. The provider had recently purchased an electronic system to record patient consultations; this was not in operation at the time of our visit as it was still being tailored to the requirements of the service.
- The provider organised quarterly workshops with the consultants granted practising privileges at the clinic, to discuss a range of topics and carry out case reviews. The minutes we reviewed mentioned the topic brought to the forum by participants but did contain the detail of what was discussed in relation to those topics. There was no record of actions.
- The provider held monthly meetings at the clinic which mainly covered issues related to the building, such as improvements to communal areas and matters arising with the landlord. There was no evidence of discussions about quality and sustainability and the meetings were not attended by the consultants granted practising privileges.
- The service used performance information which was reported and monitored, and management and staff were held to account.
- There were arrangements in line with data security standards for the availability, integrity, and confidentiality of patient identifiable data.

Engagement with patients, the public, staff and external partners

The service involved patients, the public, staff and external partners to support high-quality sustainable services.

- The service had a system in place to gather feedback from patients. For example, the service had carried out a patient survey and had feedback forms available for patients in the waiting area.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

Requires improvement

Are services well-led?

- There was no evidence that recent monitoring or quality improvement activity had led to improvements in the clinical care.
- The service made use of internal reviews of incidents. However, we did not see any documented learning that could be shared and used to make improvements.
- We saw evidence of the provider had taken steps to collaborate with other services to mitigate potential risks and reduce the concerns of patients by sharing information.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: There was limited quality improvement activity in relation to the clinical outcomes for patients. At the time of inspection there was no evidence of a process in place to follow-up on patients that were referred for secondary care. The minutes of meetings attended by the consultants granted practising privileges could not be used as a record that could be referred back to and used for follow-up purposes because they did not capture the detail of the meeting or agreed outcomes. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.