The Frater Clinic Limited

The Frater Clinic

Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 2 July 2018 and 11 July 2018 to ask the service the following key questions: Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

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

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

The Frater Clinic provides private general practitioner (GP) services and consultations with specialist consultants across a range of secondary care specialties. Forty-seven clinicians have been granted practising privileges at The Frater Clinic, including specialist doctors in cardiology, endocrinology, general surgery, gastroenterology, breast surgery, obstetrics and dermatology. The work of some of these, such as counselling and physiotherapy is out of scope of CQC registration and regulation.

Summary of findings

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.

Sixteen people provided feedback about the service, which was wholly positive.

Our key findings were:

- A number of risks, including infection, hazardous substances and fire, were not adequately assessed or mitigated.
- Recruitment records and records of staff checks were incomplete and the clinic had no systems to check the recruitment of shared reception staff or staff used as chaperones.
- There was not an effective system for monitoring the quality of care, in line with the clinical model. There was no formal quality improvement programme, and no recent evidence from audit or other quality improvement activity of improvement in patient care. There was very limited evidence of learning and improvement from patient safety alerts, incidents and complaints.
- A review of 20 patient records found instances where the care provided was not in line with local or national guidance.
- 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.
- Details of the clinic complaints policy were not available on the website. Records of the one complaint received were incomplete.
- Patient feedback for the services offered was consistently positive.

We identified regulations that were not being met and the provider must:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

There were areas where the provider could make improvements and should:

- Review information available to patients about costs of treatment and staff working at the clinic.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

- 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.
- Other risks (such as from hazardous substances and fire) were not sufficiently well assessed or mitigated.
- 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.
- Systems to ensure that all staff were aware of and acted to respond to safety alerts were not effective. The clinic assumed, but did not assure, that staff received alerts directly and acted upon them.
- The clinic's incident reporting policy was not consistent with the requirements of the Duty of Candour. Two significant events had been documented. There was evidence of learning and improvement from these.
- There were arrangements in place to respond to emergencies and major incidents, although these were not consistently implemented.

Are services effective?

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

- 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.

Are services caring?

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

- Feedback from patients was positive and indicated that the service was caring and that patients were listened to and supported.
- There were limited opportunities for patients to give written feedback.
- Systems were in place to ensure that patients' privacy and dignity were respected.
- Staff told us that treatment costs were clearly laid out and explained in detail before treatment commenced. There were different prices for GP consultations on the clinic's website and it was not clear which applied.

Are services responsive to people's needs?

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

- The service understood its patient profile and had used this understanding to develop the service. The service was designed to offer quick, easy and efficient access to both primary and secondary care.

Summary of findings

- There was some limited evidence of improvement in response to complaints and feedback.
- The complaints process was only available on request. Records of the one complaint received were incomplete.

Are services well-led?

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

- 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 Frater Clinic

Detailed findings

Background to this inspection

The Frater Clinic is run by Frater Clinic Limited, and is based at 94 Harley Street, London. The provider operates only from this location, which was visited twice for this inspection.

At the clinic, child and adult patients can access private general practice (GP) care and travel medicine services (including vaccinations). Most patients are of working age. Many are non-UK resident or are resident but 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 (if the patient prefers).

Patients pay privately for their care at the clinic, or have their care paid for by an insurance policy. 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.

Minor surgical procedures are performed at the clinic, by a specialist doctor in dermatology. If a patient needs tests or treatment that require sedation or general anaesthesia, these take place in a private hospital run by a separate provider, and the patient pays the hospital provider for these services.

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.

One GP works at the practice. They are the medical director of The Frater Clinic Limited. A second director provides non-clinical support. Forty-seven clinicians have been granted practising privileges. Most of these attend the clinic only when there is a patient who requires an appointment. One consultant specialist sees patients at the clinic on a regular day once a fortnight, including when the directors are absent. The clinic employs a cleaner to clean the three clinic rooms.

Consulting hours are 9.30am -5.30pm Monday to Friday (excluding bank holidays), for booked appointments only. When the clinic is closed, patients are directed to other services.

We visited The Frater Clinic on 2 July 2018 and 11 July 2018. The team was led by a CQC inspector, with a GP specialist advisor. The team was the same for both inspection visits.

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.

Are services safe?

Our findings

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

Safety systems and processes

Some arrangements were in place to keep people safe and safeguarded from abuse, but these were not sufficiently well implemented.

The staff member we asked could not locate a policy on safeguarding children or adults. The document we found called Child Protection was undated, had no reference to a clinic process for handling concerns or for identifying vulnerable patients or those on a child protection plan.

We asked for the training records of three doctors who had been granted practising privileges at the clinic. Of the three consultant files checked, three had no evidence of training at the appropriate level (for example, level three for doctors) in safeguarding children or adults. In response to the draft report the clinic told us that their previous policy had been to review but not retain copies of documents related to those with practising privileges. The clinic told us that the recruitment policy had now been changed. The GP (medical director) and the non-clinical director had received training appropriate to their role and understood their responsibilities. After the inspection we were sent evidence of recent training in safeguarding adults and children for two of the three doctors. We were sent the external appraisal of the third doctor, completed in May 2017, which noted that they had outstanding mandatory training.

The clinic had made no checks on the level of training or safeguarding understanding of reception staff (employed by the clinic's landlord and shared with other services in the building) or of staff used as chaperones (who were employed by other services in the building).

The clinic had arranged to use staff employed by other services in the building, in the event that a chaperone was required. There was no record of training for the people had arranged would be used as chaperones, although we were told that clinic staff had explained the role. The clinic had not performed any checks on the suitability of these people for the role, or viewed Disclosure and Barring Service (DBS) or other checks performed by their employer. (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). After the inspection we were sent a DBS check for one of the two people.

We advised the clinic in advance of the inspection that we would require access to staff files and documentation for any clinical and non-clinical staff, including those not directly employed. During the inspection, we requested recruitment documentation for the cleaner, who is contracted to work at the clinic, and for four specialist doctors who had been granted practising privileges.

One of the four specialist doctors' files we checked had complete recruitment records. One file had no complete employment history, one had no proof of identity; one had no references, one had only one reference (which was not in line with the clinic policy which stated two references were required); one had no DBS check, one had a DBS check with no readable details, and one had a DBS check requested by a different employer; two had no evidence of qualifications; one had no check of professional registration and two had no recent checks of professional registration (as checks were performed in 2009 and 2012). In response to the draft report the clinic told us that their previous policy had been to review but not retain copies of documents related to those with practising privileges. The clinic told us that the recruitment policy had now been changed.

After the inspection, we were sent the missing employment history for one of the specialist doctors.

There were no recruitment documents for the cleaner apart from a DBS check. We were sent evidence after the inspection related to the cleaner but could not review this as it contained confidential personal information that had not been redacted.

Arrangements to prevent and control the spread of infections were not sufficiently formulated or implemented to keep patients safe.

- There were no documented cleaning specifications in line with statutory guidance. The only cleaning records were logs (with the cleaners' initials) showing the dates and times that the cleaner attended to clean the clinic's rooms and that the communal toilets had been inspected. After the inspection the clinic sent us a cleaning protocol, which consisted of pages of photocopied guidance, with a clinic title page, but no

other changes to make it applicable to the clinic. The relationship between the clinic's other infection control policies and the cleaning protocol was not clear, with some information duplicated or contradictory (for example on cleaning some spillages of body fluids). There were no references to the protocol in the policies (or vice versa) to guide staff. The protocol and policies did not specify how often any area should be cleaned or how this was monitored. In response to the draft report, the clinic sent us a cleaning schedule with days of the week and tasks e.g. Dust.

- The clinic had no details of the cleaning specification for the communal areas of the building, and we noted significant dust at high and low levels in the toilets and waiting room. There was also some light dust in the room used for minor surgery in some areas at low levels and on the struts of the examination bed.
- None of the policies or protocols referred specifically to cleaning the fabric privacy screens, which we were told were wiped, but no records were kept.
- A legionella risk assessment was carried out in May 2018. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Staff immunity records we looked for in staff files were incomplete, with no evidence for any of the doctors granted practising privileges and only evidence of immunity to Hepatitis B for the GP medical director. The clinic policy refers only to Hepatitis B, and not to other vaccine-preventable diseases such as rubella (as recommended in national guidance). In response to the draft report the clinic told us that all of the doctors with practising privileges have immunity records, but that the clinic policy had been to not hold these. The clinic told us that they had now changed this policy. The clinic also told us that the GP medical doctor holds records of receiving a number of vaccinations, due to overseas travel. We were also sent evidence of the cleaner's immunity to Hepatitis B.
- There was no evidence that any staff member (including the cleaner and any of the doctors granted practising privileges) had received formal infection control training suitable for their role. In response to the draft report, the clinic told us that their previous policy had been to review but not retain copies of documents related to those with practising privileges. The clinic told us that this policy had now been changed. After the inspection we were sent evidence that the two of the specialist doctors had completed formal infection control training. The clinic sent us evidence related to the cleaner after the inspection, but we could not review this as it contained confidential personal information that had not been redacted. We were also sent evidence that the GP had completed a health and safety course, but with no evidence that this covered the required content at an appropriate level. In response to the draft report we were sent evidence of an infection control assessment, successfully completed by the cleaner and by the third specialist doctor (before the inspection).
- No infection control audit was available. After the inspection the clinic sent us evidence from the GP's appraisal which did not refer to an infection control audit. The clinic had not formally audited the infection rate after minor surgery. The clinic told us that the incidence of infection was zero, but sent no evidence to confirm this.

Risks to patients

Other risks were not sufficiently well assessed or mitigated:

- There were no control of substances hazardous to health assessments. We observed cleaning chemicals stored in an unlocked cupboard in the gentlemen's toilets, with various products (including toilet cleaner) placed at a level low enough to be accessible to small children. In response to the draft report the clinic told us that the cleaning supplies we saw were those used by the cleaners employed by the landlords for the building and that the clinic's own products were stored securely. The clinic told us that the cleaning cupboard in the communal toilets is now kept locked and how this is monitored.
- The last documented premises risk assessment was dated 2009. There was no reference to risks in communal areas of the building used by the clinic's patients. Shelving in the clinic was not wall fixed, as reported in the clinic's risk assessment nine years previously.
- Equipment owned by the clinic was monitored and maintained to ensure it was safe and fit for use. However, there were no arrangements to ensure that equipment brought into the clinic by those granted practising privileges was safe and fit for use. We were told that one doctor regularly brought an echocardiogram into the clinic and that the clinic had not ensured that this was safety tested or calibrated as they considered this the doctor's responsibility. In

response to the draft report the clinic sent us a photograph that showed a piece of equipment with stickers confirming it had been confirmed as safe and as effective.

- During the inspection, we noted that there was no documented system to reconcile samples sent for testing with results received. A log (observed in the clinic's files) had only records for samples taken in 2009. In response to the draft report the clinic told us that test request forms have duplicate copies, which are filed in patient notes and matched against the request forms when the results are received.
- The clinic's fire policy was dated 2009. There was no reference to fire risk management in the building (beyond the clinic's rooms). There was a fire risk assessment dated 2018 which had not identified risks that were found on the inspection. The risk assessment stated, "landlord programme in place" but there was no evidence that this met the criteria listed on the assessment (including testing using different alarm points). There was no audible testing of the alarm system. There were no records of completed evacuation drills. The fire risk assessment assessed the emergency signage and lighting as adequate. We noted that there was no directional signage in the communal areas and no emergency lighting. In response to the draft report, the clinic sent us evidence of an evacuation drill completed on 9 August 2018 (four weeks after the inspection).
- There was no evidence of current medical indemnity insurance for three of the four specialist doctors with practising privileges whose files we checked. After the inspection we were sent evidence of indemnity insurance for one of the specialist doctors. However, this showed that the policy expired on 1 January 2017. In response to the draft report, the clinic sent us evidence of current indemnity insurance for the three specialist doctors.

There were arrangements in place to respond to emergencies and major incidents, although these were not consistently implemented:

- The medical director and the non-clinical director had completed annual basic life support (BLS) training, in line with guidance. There was evidence that one of the three doctors with practising privileges whose files we checked had completed annual BLS training. After the inspection we were sent evidence of annual BLS training for one doctor. Evidence for a second doctor showed that that it had not been completed in the last 12 months. In response to the draft report, the clinic told us that their previous policy had been to review but not retain copies of documents related to those with practising privileges. The clinic told us that this policy had now been changed.
- There was oxygen, a defibrillator, and a supply of emergency medicines. All medicines and equipment were checked to make sure they would be effective when required. There was no paediatric pulse oximeter. In response to the draft report the clinic told us that there was now a paediatric pulse oximeter.
- There was a business continuity plan for major incidents such as power failure or building damage. This contained emergency contact details for suppliers, but did not have the details of the doctors with practising privileges or the building's landlord. In response to the draft report, the clinic told us that these details are stored in a separate folder in the clinic.

Information to deliver safe care and treatment

All patient records were paper-based, and were held in locked storage within the premises. We were told that the clinic was aware of guidance that provision should be in place for records retention, but no arrangements had been made.

There were no registers of patients with particular medical conditions or on particular medicines, making it difficult for the practice to carry out searches in the event of safety alerts or to inform a process of quality improvement. In response to the draft report, the practice told us that there were few patients on repeat prescriptions such that they are individually known to the clinic, without a register.

There was no formal recall system for patients with long term conditions. In response to the draft report, the clinic told us that very few patients have long term conditions and each case is known to clinic staff.

The clinic had a policy that stated records would be audited every three months, but this was not occurring. In response to the draft report, the clinic told us that auditing now occurred after each consultation with a specialist doctor.

Are services safe?

There were no routine checks on the identity of patients or on the parental authority of adults accompanying children at appointments, although clinic staff told us that they would request identity if they had any suspicions about the status of a child.

Safe and appropriate use of medicines

Prescribing protocols did not refer to the use of any external guidelines or have any information as to arrangements for safe prescribing of high risk medicines.

There was no log of decisions taken on patient safety alerts, including the recent alert on valproate prescribing in women of childbearing age/potential. Clinic staff showed us that alerts were received and told us that all relevant alerts were acted upon. Staff told us that the valproate alert was not relevant as no patients were prescribed this medicine. After the inspection we were sent evidence that one patient had been contacted in response to one alert (on glucose testing strips). There was no effective system to ensure that all staff received and acted upon patient safety alerts. Patient safety alerts were not distributed to consultants who had been issued practising privileges by the clinic. The clinic assumed, but did not assure, that staff received alerts directly and acted upon them.

There were no recent two cycle audits of prescribing. The GP medical director attended a peer group meeting, and told us that she carried out audits with this group. In response to the draft report, we were sent evidence of a meeting in 2010 when a group audit was discussed. The minutes discussed a one-cycle audit of 14 patients.

We reviewed the records of 20 patients, because we did not have sufficient evidence of safe prescribing from the clinic's governance and monitoring systems. We found one patient was prescribed six months of a disease-modifying anti-rheumatic drug (DMARD), which needs regular monitoring, with no arrangements for the prescriber to review blood test results. After the inspection the clinic told us that they had prescribed the medicine as they understood the specialist doctor who prescribed previously was liaising with the patient's local doctor and that the patient understood the need for monitoring and was having regular blood tests in her home country. In response to the draft report, the clinic sent us the evidence we had seen on the inspection of monitoring before the prescription was given. No evidence was provided that the monitoring arrangement in place allowed the prescriber to verify that the medicine continued to be safe for the patient during the whole period prescribed for. There was also an instance of antibiotic prescribing that was not in line with local or national guidance.

The medicines we saw in the clinic were stored appropriately and monitored. On both visits the vaccine refrigerator was within the required temperature range and there were no vaccines on the premises on the days we inspected. The clinic was not carrying out daily refrigerator checks (in line with its policy) and had not introduced any other policy that would ensure that vaccines would be safely managed when brought onto the premises. In response to the draft report, the clinic told us that daily monitoring is carried out when there are vaccines in the clinic and weekly monitoring at other times.

Prescriptions were handwritten. Prescription stationery was stored securely and monitored.

Track record on safety

There was an incident reporting policy, which specified that all incidents, including near misses must be reported to the medical director and documented. We were told that there had only been one event recorded (in 2012). Review of documents led to the finding that at least one other significant event had occurred, which was written up for the GP's appraisal in 2014, but was not collated with the other incident in the clinic. No significant events had been reported by any of the 47 clinicians with practising privileges.

Lessons learned and improvements made

The clinic's incident reporting policy was not consistent with the requirements of the Duty of Candour. The policy stated that patients must be informed and receive an apology and the complaints procedure if they were affected by a near miss or a low level adverse event, but these were not listed as actions to be taken if a patient was affected by a more serious adverse event or a 'never event'.

Very few incidents had been recorded. There was some evidence of learning and improvement from the two significant events that we saw documented. For example, after an incident where a patient attempted to gain medicines fraudulently using a clinic prescription, the clinic changed to prescription stationery with additional security features and improved monitoring.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

Prescribing protocols did not refer to any external guidelines or guidance. In response to the draft report the clinic told us that the guidance used is that contained in the British National Formulary. Clinic protocols for managing specific medical conditions (diabetes, asthma, hypertension) had not been updated since 2015 and referred to printed guidance dated 2013. Malaria prophylaxis guidance in the practice dated from March 2017 and we noted during the inspection that the doctor we asked found difficulty in locating the latest guidance on the internet. The latest guidance on malaria prophylaxis was issued by Public Health England in October 2017. In response to the draft report the clinic told us that the staff member would have produced the guidance if we had waited.

Evidence from patient records showed that prescribing was not always in line with relevant and current evidence based guidance and standards.

When a patient needed referring for further examination, tests or treatments they were generally referred to a specialist doctor who had been granted practising privileges by the clinic, although we were told that alternative arrangements were made if the patient requested.

Monitoring care and treatment

The clinic had not established an effective system for monitoring the care and treatment provided by all staff and by the service as a whole. There were no recent two cycle audits of prescribing. The GP medical director attended a peer group, and told us that she carried out audits with this group. In response to the draft report, we were sent evidence of a meeting in 2010 when a group audit was discussed. The minutes discussed a one-cycle audit of 14 patients. The clinic did not carry out any formal monitoring of the care and treatment delivered by the specialist doctors granted practising privileges, as the directors considered that that was addressed by the system of individual appraisals that doctors receive. No evidence of current smear adequacy rates was available. We were told that this would need to be requested from the testing laboratory. In response to the draft report, the clinic sent us evidence of a 100% adequacy rate from January 2016 to June 2018.

There was no recent evidence of improvement in patient care resulting from quality improvement activity. There were no recent two-cycle audits that resulted in improved quality of care.

The most recent audit was a survey in 2015 of prostate specific antigen (PSA) to investigate whether patients' PSA levels were affected by long haul flights. The audit 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.

A cholesterol audit was carried out in 2013. This showed a deterioration in control of cholesterol, with the percentage of patients with a random cholesterol greater than 5 mmol/L increasing from 14% in 2011/12 to 33% in 2012/13. The audit had no assessment of whether the treatment provided to patients with high cholesterol was in line with national or local guidelines. The cholesterol audit had not been repeated. In response to the draft report, the clinic told us that the audit looked at the cholesterol monitoring results for a period of three years for the same group of patients to assess the impact of health education provided by the clinic. The clinic told us that the audit demonstrated a decrease in high cholesterol from 51% to 20% over the three-year period 2009/10 – 2011/12. The clinic told us that the apparent deterioration in 2012/13 was due to a new group of patients being studied. This is not noted in the audit.

The clinic did not carry out benchmarking against quality standards of the care provided by all staff. The GP medical director attended a peer group, and told us that she carried out audits with this group. In response to the draft report, we were sent evidence of a meeting in 2010 when a group audit was discussed. The minutes discussed a one-cycle audit of 14 patients. The clinic did not carry out any formal benchmarking of the care and treatment delivered by the specialist doctors granted practising privileges. We were told that the clinic relied on the expertise of those specialist doctors, and were sent, in response to the draft report, a summary of the topics covered in national medical appraisals.

Are services effective?

(for example, treatment is effective)

The GP attended peer meetings where best practice guidance and complex cases were discussed. This was described as quality improvement, but there was no evidence that this had improved patient care.

Effective staffing

There was no documented induction checklist for the specialist doctors who were granted practising privileges. We were told that, in almost all cases, these doctors only saw patients when the medical director was in the clinic, and that they would ask for any information required, however one specialist doctor did work in the clinic without the medical director present. In response to the draft report, the clinic told us that there was an induction booklet available to doctors granted practising privileges and that this was in the clinic on the day of the inspection.

Training records were incomplete, with no confirmation that all staff had completed training in basic life support, safeguarding and infection control. There was also no evidence that any of the doctors with practising privileges had completed training in fire safety, health and safety or information governance. After the inspection we were sent evidence that one of the specialist doctors had completed all of this training, and that one had completed all apart from information governance.

There was evidence of practising qualifications in two of the four files of doctors with practising privileges. There was no evidence of any specialist update training.

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.

In response to the draft report, the clinic told us that their previous policy had been to review but not retain copies of documents related to those with practising privileges. The clinic told us that this policy had now been changed. The GP was unable to show us evidence during the inspection of ongoing quality monitoring of cervical sampling, for example, recent data on inadequacy rates. In response to the draft report, the clinic sent us evidence of a 100% adequacy rate from January 2016 to June 2018.

The clinic policy stated that doctors requesting practising privileges must supply evidence of annual appraisal. None of the files we checked had evidence of an appraisal, although we were told that they were reviewed by the medical director. After the inspection we were sent evidence of a national appraisal for one specialist doctor, completed in November 2017, which stated that the doctor had not completed the expected training. There was no evidence that this had been followed up by the clinic. In response to the draft report, the clinic sent us evidence of infection control training completed by the doctor in June 2018, with a note that this was the outstanding training. The clinic also told us that their previous policy had been to review but not retain copies of documents related to those with practising privileges. The clinic told us that this policy had now been changed.

Coordinating patient care and information sharing

When a patient contacted the clinic they were asked if they were registered with an NHS GP, and if so, 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 private GP (who is the medical director) would, with the patient's consent, enter the room at the end of the consultation to facilitate coordinated patient care.

Supporting patients to live healthier lives

Health promotion information was available at the clinic and on the website.

Clinic staff told us that they referred patients for smoking cessation when required.

Consent to care and treatment

The GP understood and sought patients' consent to care and treatment in line with legislation and guidance. There was no evidence that doctors who had been granted practising privileges had received training on the Mental Capacity Act 2005. After the inspection we were sent evidence of this for two specialist doctors. In response to the draft report, the clinic told us that their previous policy had been to review but not retain copies of documents related to those with practising privileges. The clinic told us that the policy had now been changed.

Are services caring?

Our findings

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

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 16 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.

There were limited opportunities for patients to give written feedback to the clinic. Some patients were contacted to provide feedback for the GP's revalidation (every five years). Thirty two patients had given feedback in 2017, and all of this was positive. In between these feedback periods, some patients were given paper survey forms – we were told that these would be mainly new patients and patients who had seen specialist doctors granted practising privileges. We were shown an unlabelled lidded box on top of a filing cabinet, which we were told was a comments box. Inside were six completed survey forms. Two forms were undated, two were dated 2010 and one was dated 2012. All rated all aspects of the clinic very positively. There was no facility for patients to review the service online.

There was no facility for patients to review the service online.

Involvement in decisions about care and treatment

The relationship between the clinicians 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. The clinic website described these clinicians as "our doctors" and "our specialist team", but the directors believed that in the event of a patient wishing to take legal action they could do so only against the individual doctor – not against the clinic. This was not stated on the website, the registration form or the clinic's complaints policy.

Feedback from the clinic's surveys indicated that staff listened to patients concerns and involved them in decisions made about their care and treatment.

The service used a number of means to communicate with patients who did not speak English as their first language. They employed clinicians who spoke some other languages, and there was access to a telephone translation service and face-to-face translators when required. There was no hearing loop, but staff told us how they would support patients who had a hearing impairment.

Staff told us that treatment costs were clearly laid out and explained in detail before treatment commenced, although we noted that the clinic website stated two different prices for an appointment with a GP.

The clinic told us that the GP medical director's participation at the end of specialist consultations helped to ensure that patients understood the information given by the specialist doctor and supported them to participate in the decision making about treatment options.

Privacy and Dignity

The provider respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The service had systems in place to facilitate compliance with data protection legislation and best practice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

The majority of the clinic's patients were of working age. The service was designed to offer quick, easy and efficient access to both primary and secondary care, in a central London location, to avoid patients having to wait or have undue time off work for appointments.

Consultations were available to any person who paid the fee directly or through insurance cover.

The facilities and premises were generally appropriate for the services delivered, although the risks of infection and from fire had not been adequately mitigated.

Patients had access to in-house psychological and physiotherapy services, with clinicians who had been granted practising privileges.

Timely access to the service

Consulting hours were 9.30am -5.30pm Monday to Friday (excluding bank holidays).

Appointments with the GP lasted 30 to 60 minutes, to allow full discussion of a patient's health.

Patients could often be seen by specialist doctors the same or the next day that they saw the GP.

Listening and learning from concerns and complaints

There were limited opportunities for patients to give written feedback. Some patients were asked to give feedback for the GP's five yearly revalidation and some, mainly new patients and patients who had seen doctors granted practising privileges, were given paper feedback forms.

There was no information on how to complain in the waiting room. We could not see any in the consulting rooms, although in response to the draft report we were told that it was available in a patient guide. Details of the clinic complaints policy were not available on the website. One complaint had been received. We were told that this was received verbally, but there was no record of the conversation. The letter sent to the complainant did not refer to the arrangements (stated in the clinic policy) if the complainant was not satisfied with the clinic's response.

The clinic told us that in response to the complaint, the clinic now made efforts to offer bereavement condolences to the extended family of patients.

There was some limited evidence of improvement in response to complaints and feedback. Staff told us that feedback had led to the clinic sourcing new providers for tests (e.g. ultrasound scans) and that there were plans to work with the building's owner on redecoration of the communal areas.

Are services well-led?

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

Our findings

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

Leadership capacity and capability

The directors had not recognised and addressed the challenges presented by the delivery model adopted, particularly the complexities of governance associated with sharing staff and premises with other services and delivering care through the granting of practicing privileges. We were told that the main challenge to providing good care was that some people could not afford to access the service.

Vision and strategy

The directors had a clear vision of integrated primary and secondary care, with plans to increase the number of clinicians granted practicing privileges at the clinic, but did not have adequate governance arrangements in place to ensure that the care delivered was safe and was of a consistently high quality. There was not an effective system for monitoring the quality of care, in line with the clinical model.

Culture

The directors aspired to a culture of high quality holistic care, but systems were not established to ensure that it was consistently delivered.

- The directors had not ensured that all staff involved with delivering the service were suitable for the role, including non-clinical staff employed by other services.
- There were no meetings or other regular communication between the directors and staff involved with delivering the services, other than that between clinicians related to the day-to-day care of patients.
- Minutes of director meetings we were shown during the inspection had no details of what was discussed (other than the topic) and no recorded actions. We were told that the notes had been written up as meetings but were actually the result of ongoing informal discussion. In response to the draft report we were sent minutes of a meeting between the directors in April 2017, which were an agenda and some very brief action points, with no detail that would allow for these to be followed up.
- The service had assumed, but did not ensure, that clinicians who had been granted practising privileges had up-to-date training and access to the latest alerts and guidance.
- No appraisals were carried out by the clinic. We were told that the medical director reviewed the appraisals of those granted practising privileges that had been carried out by other organisations but there was no evidence of this in the files we checked. After the inspection we were sent one appraisal.
- The incident reporting policy was not consistent with the requirements of the duty of candour.

Governance arrangements

Directors had not established proper policies, procedures and activities to ensure safety and had not assured themselves that systems were operating as intended.

- Governance documents were not arranged in such a way to allow staff to locate policies when required. Policies in place included a swimming pool protocol (there is no swimming pool at the clinic). In response to the draft report, the clinic told us that the governance documents had been rearranged for the CQC inspection, and that the swimming pool policy relates to another organisation with which the GP medical director works.
- Some of the policies we reviewed were undated (e.g. the complaints policy and the cleaning protocol). Other policies, protocols and assessments seen on the inspection were dated 2009, 2013, 2014 and 2015. In response to the draft report, the clinic told us that governance documents were reviewed annually and sent us a policies and protocols review document as evidence of this. The review document listed 79 policies, although not all of the documents that we saw were listed. The review document records that all of the 79 policies listed were reviewed by the medical director on one day in January 2018. No action is noted as needed with regards to the policy on checking vaccine fridge temperatures, which we found was no longer being followed.
- Most of the recruitment and personnel files we reviewed did not have the required records or staff checks. Some of the evidence was provided after the inspection. There was no effective system to ensure that staff had completed the expected training. In response to the

Are services well-led?

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

draft report the clinic told us that their previous policy had been to review but not retain copies of documents related to those with practising privileges. The clinic told us that this policy had now been changed.

- The clinic was not following several of its own policies, for example, on records audits. In response to the draft report, the clinic told us that auditing now occurred after each consultation with a specialist doctor.
- There were policies setting out how to manage concerns about a doctor's performance, but monitoring systems were not in place to ensure that issues would be identified. Of the four specialist doctors' files we looked at, three had copies of signed codes of ethics and governance policies, the fourth file did not.

Managing risks, issues and performance

Processes for managing risks, issues and performance were not effective.

- We identified a number of risks (such as those related to infection control, fire, and substances hazardous to health) which were not adequately assessed or mitigated. These had not been identified and rectified by the clinic risk processes.
- Although we were told that individual clinical staff attended educational events, there was no documented systematic approach to quality improvement, and no evidence that the activities undertaken had led to improved patient care.
- The clinic carried out no formal monitoring of consultations, prescribing or treatment decisions of the doctor's granted practising privileges. The clinic told us that the GP medical director discussed case studies, prescribing and referrals at a peer meeting. In response to the draft report, we were sent evidence of a meeting in 2010 when a group audit was discussed. The minutes discussed a one-cycle audit of 14 patients. There was no active audit programme, and no recent evidence from audit or other quality improvement activity of improvement in patient care.
- There was very limited evidence of learning and improvement from patient safety alerts, incidents and complaints.

Appropriate and accurate information

- There were no registers or systems to allow for searches or reactive recall of patients with long term conditions or those taking medicines on repeat prescription. In response to the draft report, the practice told us that there were few patients on repeat prescriptions or with long term conditions, such that they are individually known to the clinic, without the need for a register to be kept.
- There was no performance data for the doctors granted practising privileges. The GP medical director had recently had their external appraisal, but there was no other recent performance data. There was evidence of involvement with a group prescribing audit in 2010. There was limited data on the views of patients. There was no routine system in place for obtaining written feedback about the clinic and the doctors granted practising privileges. The GP medical director was required to gather patient feedback for their appraisal and thirty-two patients responded.
- None of the meeting minutes we reviewed during the inspection showed discussion on quality or sustainability. In response to the draft report we were sent minutes of a meeting between the directors in April 2017, which were an agenda and some very brief action points, with no details of the discussion. The agenda items included refurbishment. We were told that the clinic was in discussion with the building landlord as to redecoration plans and that these (when complete) would improve the quality of the patient environment.
- No arrangements were in place for the retention of records in the event that the clinic ceased to operate.
- The clinic had policies designed to ensure compliance with data security legislation. However, on three occasions after the inspection we were sent documents in which confidential patient and staff details had not been redacted. On two occasions documents were sent with no redaction, on the third details had not been sufficiently obscured to ensure the patient could not be identified.

Engagement with patients, the public, staff and external partners

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.

Continuous improvement and innovation

There was no evidence that recent monitoring or quality improvement activity had led to improvements in the clinical care or services provided.

Are services well-led?

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

There was evidence of some improvements to specific processes following the two significant events, however the risks and issues we found on the inspection had not been identified and rectified by the clinic processes.