The Staunton Group Practice

Inspection report

Morum House Medical Centre
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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	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Inadequate**
Are services caring?	**Inadequate**
Are services responsive?	**Inadequate**
Are services well-led?	**Inadequate**

Overall summary

This practice is rated as Inadequate. (Previous rating August 2017 and May 2018 – Inadequate)

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Inadequate

Are services caring? – Inadequate

Are services responsive? – Inadequate

Are services well-led? - Inadequate

We carried out an announced comprehensive inspection at the Staunton Group Practice on 2 October 2018. Following a previous comprehensive inspection in August 2017, the practice had been placed in special measures as we had noted significant safety concerns. We carried out a focussed inspection in November 2017 and a further comprehensive inspection in May 2018, at the end of the special measures period, when we found there had been insufficient improvement and identified more concerns which put patients' safety at risk. Accordingly, we imposed an urgent suspension of the provider's registration, with effect from 9 May 2018 to 23 October 2018. During that period, a caretaker practice was put in place by NHSE (London) commissioners to provide the service. The reports of the previous inspections can be found by selecting the 'reports' link for Staunton Group Practice on our website at www.cqc.org.uk/location/1-573879781.

At this inspection on 2 October 2018 we found:

- Although some action had been taken since our previous inspections, it was insufficient to address all the safety and governance concerns noted, or to improve the effectiveness of the service. Changes made had been implemented by the caretaker practice with minimal involvement by the Staunton partners. We were not assured the practice had effective systems in place to keep patients safe and to protect them from risk of abuse or harm.
- The practice could not provide evidence that health and safety risk assessments had been carried out.
- No protocol had been established to manage patients' records transferred from other practices, to ensure complete medical histories were maintained.
- Clinical audits carried out by the caretaker practice had identified significant issues relating to prescribing practice.
- There was no evidence that clinical audit by the practice was driving improvement. For example, an audit carried out in August 2018 had identified the need for further staff training, but this was not programmed before February 2019.
- The system for identifying and managing significant events and for handling patients' complaints remained ineffective. Staff could not access records for us to review.
- The practice could not provide evidence that all staff had received training or appraisals.
- The practice's results from the national GP Patient survey relating to the service being caring and responsive were in some cases significantly below local and national averages. The practice had taken insufficient action to address the concerns.

We again found the practice had made insufficient improvements and that patients would remain at significant risk should the suspension lapse and the practice's registration be reinstated. Accordingly, we re-imposed the urgent suspension of its registration, under s31 of the Health and Social Care Act 2008 (the Act), from 24 October 2018 until 24 April 2019, intending to escalate our enforcement action to cancel the practice's CQC registration.

We subsequently established that the practice continued to provide regulated activities whilst the registration was suspended. We therefore took urgent action to cancel the registration, under s30 of the Act, with an order being made by Highbury Corner Magistrates on 6 November 2018. The provider appealed against that order at a hearing before the First Tier Tribunal (FTT) in January 2019. The FTT confirmed the decision to cancel the practice's registration on an urgent basis and dismissed the appeal. The practice then applied for permission to appeal to the Upper Tribunal against the FTT's decision. That application was refused by the Upper Tribunal on 18 July 2019. Accordingly, we have now proceeded to cancel the practice's registration.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Population group ratings

Older people	**Inadequate**
People with long-term conditions	**Inadequate**
Families, children and young people	**Inadequate**
Working age people (including those recently retired and students)	**Inadequate**
People whose circumstances may make them vulnerable	**Inadequate**
People experiencing poor mental health (including people with dementia)	**Inadequate**

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser, a practice nurse specialist adviser and a practice manager adviser.

Background to The Staunton Group Practice

The Staunton Group Practice (the practice) is based at Morum House Medical Centre, 3-5 Bounds Green Road, Wood Green, London N22 8HE. It shares the premises with other healthcare services.

The practice's CQC registration relates to the following regulated activities - Diagnostic and screening procedures, Family planning, Maternity and midwifery services, Surgical procedures, and Treatment of disease, disorder or injury. The practice's CQC registration is for a partnership of four GPs. Shortly before our inspection in May 2018, we received notice that two of the GPs would be leaving the partnership. One would remain working in the service as a salaried GP; the other would be leaving it entirely. However, due to the concerns we identified at the May 2018 inspection we put the processes to make changes to the registration on hold.

The practice is part of the NHS Haringey Clinical Commissioning Group (CCG) which is made up of 51 general practices. The practice provided NHS primary medical services through a General Medical Services (GMS) contract to approximately 14,700 patients. Following our inspection in May 2018, we suspended the practice's CQC registration, having identified significant concerns, which put patients' safety at risk. The period of suspension was from 9 May 2018 to 23 October 2018. Service commissioners put a caretaker practice in place for the duration of the suspension. The caretaker practice was responsible for the service at the date of our inspection. However, some of the practice partners and salaried GPs continued to work in the service as locums, to provide some continuity of care for patients.

The practice partnership is made up of four GPs. It employed three salaried GPs. One of the salaried GPs was on extended leave. The practice used a number of regular locum GPs. There was a locum nurse practitioner, three locum nurses and a healthcare assistant. The new practice manager had been appointed in July 2018. There were 16 other staff in the administrative / reception team. The practice employed three caretakers / cleaners.

The service operates between 8.00 am and 7.00 pm, Monday to Friday, which include a 30 minute "extended hours" period each evening. It closed at weekends. Phones are operated between 8.00 am and 6.30 pm. Routine appointments are 10 minutes long and may be booked up to four weeks in advance. Double-length appointments can be booked, if needed. GPs also provide daily telephone appointments and carry out home visits to patients who are housebound or are too ill to visit the practice.

The CCG provides an extended hours service at three "hubs" across the borough, which operate between 6.30

pm and 8.30 pm, Monday to Friday and between 8.00 am and 8.00 pm on Saturdays and Sundays. All patients registered with Haringey practices may book appointments with the extended hours service.

The practice opted out of providing an out of hours service. Patients calling the practice when it is closed are connected with the local out of hours service provider.

Inadequate

Are services safe?

We rated the practice as inadequate for providing safe services following our inspections in August 2017 and May 2018.

The practice did not have effective systems in relation to safeguarding, handling significant events and safety alerts, medicines management, infection prevention and control, maintaining patients' records and managing health and safety risks to staff and patients.

We have again rated the practice as inadequate for providing safe services because:

- Although the practice had taken some action since our previous inspections, it had been insufficient to address all the concerns noted.
- The systems to keep patients safe and to protect them from risk of abuse or harm were inadequate.

Safety systems and processes

The practice did not have clear systems to keep people safe.

At our previous inspections in August and November 2017, we found the practice did not have effective systems and processes in place to safeguard patients from abuse.

At our inspection on 2 October 2018, we were told the service's safeguarding processes had been reviewed. However, we found practice partners had limited involvement, with most of this work having been completed by the caretaker practice. When we asked practice partners to explain the new procedures they had limited knowledge of them, providing no assurance the changes made would be sustained or managed effectively. Practice partners said work on reviewing and improving adult safeguarding records was still ongoing. The adult safeguarding register was limited to patients on care plans. They told us the practice had plans, not yet implemented, to establish a register that included patients from various at-risk groups. Until the processes were in place and running effectively, we could not be assured all patients were receiving care and treatment appropriate to their needs.

Risks to patients

There were not adequate systems to assess, monitor and manage risks to patient safety.

At our inspection in May 2015, the acting practice manager told us they had not been given access to all the previous practice manager's files. These included safety records, such as risk assessments and inspection certificates. Accordingly, there was no assurance that risks to patients, staff and visitors were effectively reviewed, assessed and managed.

At our inspection on 2 October 2018, we met the new practice manager, appointed in July 2018, who told us they too had not been given access to the safety records. Therefore, we could still not establish whether risk assessments relating to, for example, general health and safety, security, fire safety and the storage of hazardous materials had been carried out.

At our inspection in May 2018, we found the system for the receipt and dissemination of safety alerts was not effective in reducing risks to patient safety.

At our inspection on 2 October 2018, we found that the caretaker practice had introduced an appropriate system for handling safety alerts, but with little input from the practice partners who were not able to explain what the new system entailed.

Information to deliver safe care and treatment

Staff did not have the information they needed to deliver safe care and treatment to patients.

At our inspection in May 2018, we found there were 615 patients who had transferred from other GP services since 2016, whose medical records had not been merged with those set up by practice. Accordingly, the records used by practice staff when providing care and treatment were incomplete, putting the patients at significant risk of harm.

At our inspection on 2 October 2018, practice partners told us administrative staff had been trained appropriately to process transferred records and most of the 615 patients' notes had been consolidated to make up full records and medical histories. However, five of the outstanding patients' records remained to be consolidated and no written protocol had been drawn up to ensure this significant issue was not repeated.

Appropriate and safe use of medicines

The practice did not have reliable systems for appropriate and safe handling of medicines.

Inadequate

Are services safe?

At our inspection in May 2018, we found the practice did not have reliable systems for appropriate and safe handling of medicines. Patients' health was not consistently monitored in relation to the use of high risk medicines or followed up appropriately.

At our inspection on 2 October 2018, the practice partners told us prescribing protocols had been revised. However, we saw this had been carried out exclusively by the caretaker practice, which had also produced various guidance notes to staff and an explanatory leaflet for patients. The caretaker practice's clinical pharmacist had carried out five prescribing audits which had highlighted significant concerns which needed to be addressed to ensure continuing patient safety. By failing to appropriately monitor and manage patients prescribed high risk medicines, the practice had put patients at significant risk of harm or death.

Track record on safety

The practice had a poor track record on safety.

Significant safety concerns had been identified at out inspections in August 2017, resulting in the practice being put in special measures, and again in May 2018, when the practice's registration was suspended. At this inspection, we found that the practice had again failed to make sufficient improvements so that risks to patients' safety remained a significant concern.

Lessons learned and improvements made

The practice did not learn and or make improvements when things went wrong.

At our previous inspections in August and November 2107, we found the practice's processes for reporting, recording and investigating significant events was ineffective. This exposed patients to the risk of harm. At our inspection in May 2018, the practice had not acted to introduce an effective system.

At our inspection on 2 October 2018, practice partners told us the significant events process had been reviewed. This had highlighted that previously staff had perceived there to be a "blame culture", making them unwilling to report incidents. The caretaker, with some input from practice partners, had developed guidance and a revised, simplified, reporting form to record new significant events and there had been some discussion at staff meetings regarding the new processes. However, staff could not access the records we had seen at our previous inspections and we could not establish what action if any had been taken to investigate and review them since. Accordingly, we could not be assured the practice had an effective system to review and learn from recent or historical significant events.

Please refer to the Evidence Tables for further information.

Inadequate

Are services effective?

We rated the practice as inadequate for providing effective services overall and across all population groups following our inspections in August 2017 and May 2018.

We have again rated the practice as inadequate for providing effective services overall and across all population groups because:

- The practice had taken insufficient action to address all the concerns noted at our previous inspection to improve the effectiveness of the service. This applied to all population groups.
- People's outcomes were variable or significantly worse than expected when compared with other similar practices. Necessary action was not taken to improve people's outcomes.
- Partners did not have a clear understanding of the revised process for managing two-week referrals to secondary care in cases of suspected cancer.
- There was limited evidence that clinical audit drove improvement.

Effective needs assessment, care and treatment

At our inspection in May 2018, we found the practice had introduced a process to ensure that clinicians were aware of relevant and current evidence-based guidance and standards, including NICE best practice guidelines.

Because we have rated the practice as inadequate for all key questions, we have also rated all the population groups as inadequate. We noted the following:

Older people:

- There was insufficient evidence that all patients prescribed repeat medicines had received a medicine review to ensure their healthcare needs were being met.

People with long-term conditions:

- There was insufficient evidence that all patients with long-term conditions had a structured annual review to check their health and medicines needs were being met.
- Performance data showed that outcomes for patients with long term conditions such as diabetes, asthma, COPD, hypertension and atrial fibrillation remained below local and national averages, in some cases significantly so.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were below the target percentage of 90% or above, for all four indicators, with three indicators significantly lower than the target

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening remained below local and national averages. Its process for managing patients' cervical screening did not ensure that patients with positive test results were followed up appropriately.

People whose circumstances make them vulnerable:

- The adult safeguarding register was limited to patients on care plans. Partners told us the practice had plans, not yet implemented, to establish a register that included all patients with learning disabilities, "Mental Health with history of self-harm", homeless patients and sex workers. Until the process was put in place, we could not be assured all patients were receiving care and treatment appropriate to their needs.

People experiencing poor mental health (including people with dementia):

- Data showed that only 80% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This was below the CCG and national averages, both being 90%.
- Data showed that 4 out of 9 patients prescribed lithium, used for treating bipolar disorder, were overdue a review.

Monitoring care and treatment

The practices programme of quality improvement activity to review the effectiveness and appropriateness of the care provided remained inadequate.

The practice participated in the Quality Outcome Framework (QOF), a system intended to improve the quality of general practice and reward good practice. The published QOF results for 2017 /18 showed the practice had achieved 92% of the total number of points available, being 3 and 4% below the clinical commissioning group (CCG) average and national average, respectively. The clinical exception reporting rate was 8%, slightly below both the CCG and national averages. Exception reporting is

the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate. Published data showed that various performance indicators were consistently below local and national averages and when compared with data from previous years showed a downward trend in the practice's performance.

At our inspection in May 2018, insufficient evidence was provided to demonstrate the practice had effective clinical audit processes in place to drive improvement. Prior to our inspection on 2 October 2018, at our request, the practice sent us three examples of clinical audits. These included audits of inadequate cervical screening tests. One, containing data from August and September 2018, had highlighted the need for one of the nurses to receive update-training. However, the training was not to be provided until February 2019, potentially putting patients at risk in the meantime.

Effective staffing

At our inspection in May 2018, we found some staff had the skills, knowledge and experience to carry out their roles. However, we identified issues relating to safety and risk management at the practice. New administrative systems had been introduced, without all staff being appropriately trained. Staff were not always deployed or tasked appropriately to ensure the effective operating of the service. For example, reception staff were limited to two on duty at a time, leading to long patient queues and delays.

At our inspection on 2 October 2018, we were told there had been a significant turnover of staff since the urgent suspension was imposed. However, due to the practice manager not having access to all records, we could not establish that any of the new or existing staff had completed mandatory or refresher training appropriate to their role. The practice was also not able to demonstrate that all staff had received an annual appraisal including any since the urgent suspension of registration.

Coordinating care and treatment

At our previous inspections, we found the practice's system for monitoring patients' two-week referrals in case of suspected cancer was inadequate.

At our inspection on 2 October 2018, practice partners told us the system had been reviewed. The practice partners showed us a revised spreadsheet monitoring log, which they said had been developed by the practice's administrative staff, working with the caretaker. However, when we asked, the practice partners were not able to explain some aspects of the monitoring process or the spreadsheet log. We raised this with the caretaker's staff, who subsequently informed us that the practice partners had described a previous version of the new monitoring process and shown us an older form of the monitoring log. We could not be assured, therefore, that the practice could operate and maintain the process effectively to bring about and sustain improvement which put patients requiring these referrals at significant continuing risk of harm.

Helping patients to live healthier lives

- Staff told us the practice worked to identify patients who may be in need of extra support and directed them to relevant services. Published data showed the practice's performance was comparable with local and national averages in relation to these specific indicators.

Consent to care and treatment

Consent to care and treatment was obtained in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the evidence tables for further information.

Inadequate

Are services caring?

We rated the practice as inadequate for providing caring services following our inspection in May 2018.

We have rated the practice as inadequate for providing caring services because:

- We saw from the 2018 GP patient survey, using data collected before the May 2018 suspension, that patients' satisfaction over caring aspects of the service remained significantly lower than local and national averages.
- These issues had been noted at previous inspection, but insufficient action had been taken to address them.
- Staff did not always treat patients with kindness, respect and compassion.
- The practice did not always help patients to be involved in decisions about care and treatment.
- The practice did not always respect patients' privacy and dignity.

Kindness, respect and compassion

Staff did not always treat patients with kindness, respect and compassion.

- Feedback from patients completing our comments cards was mixed about the way staff treated people.
- The practice's results from the most recent national GP patient survey remained significantly below CCG and national averages.
- There was limited continuity of care.

Involvement in decisions about care and treatment

The practice did not always help patients to be involved in decisions about care and treatment.

- A telephone interpreting service was available at short notice and interpreters could be booked to attend appointments with patients with three days' notice. However, there was limited information about the service in languages other than English at the premises and on the website. During the process for agreeing the factual accuracy of our draft inspection report, the practice told us that staff members could speak 15 languages between them, to provide some assistance to patients for whom English is a second language.
- There was a hearing loop, but patient feedback indicated that practitioners of British Sign Language, to assist people with hearing disability, were not available. During the process for agreeing the factual accuracy of our draft inspection report, the practice told us that sign language service was available, funded by the Haringey CCG.
- There were no available communication aids or easy read materials, for children or people with learning disabilities.
- Staff helped patients and their carers find further information and access community and advocacy services. There was information on the practice website, signposting carers to support organisations. However, the practice had identified 142 carers, just under 1% of the patient list.

Privacy and dignity

The practice did not always respect patients' privacy and dignity.

- The practice's results of the GP patients survey were below CCG and national averages regarding patients' experience at reception: 76% of patients said they found the receptionists at the practice helpful, compared with the CCG average of 87% and the national average of 90%.

Please refer to the Evidence Tables for further information.

Inadequate

Are services responsive to people's needs?

We rated the practice as inadequate for providing responsive services following our inspections in August 2017 and May 2018.

At our previous inspections we found that services did not meet patients' needs. There were ongoing concerns for patient's accessing the service. Patients found the appointments system problematic; telephone access was difficult and patients told us there were frequent delays at reception and whilst waiting to see clinicians.

We have again rated the practice as inadequate for providing responsive services because:

- The practice had taken insufficient action to address all the concerns noted at our previous inspections.
- The practice did not organise and deliver services to meet patients' needs. It had not undertaken any analysis of patients' needs and preferences.
- People were not able to access care and treatment within an acceptable timescale to meet their needs.
- The practice's complaints process did not ensure that patients' concerns were properly investigated, addressed and learned from. Complaints and concerns were handled inappropriately and there was a lack of transparency in how they were handled. They did not lead to improvements in the quality of care.
- Because we have rated the practice as inadequate for all key questions, we have also rated all the population groups as inadequate.

Responding to and meeting people's needs

The practice did not organise and deliver services to meet patients' needs. It did not take account of patient needs and preferences. However, we noted the following:

Older people:

- The practice offered home visits for those with enhanced needs. Requests were triaged by the duty GP

People with long-term conditions:

- Staff told us that patients with a long-term condition were offered an annual review with practice nurses to check their health and medicines needs were being appropriately met. However, published data showed that outcomes for patients with long term conditions were below local and national averages.
- Staff attended multi-disciplinary team meetings to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- Double appointments were available for children's appointments.

Working age people (including those recently retired and students):

- Early morning and evening appointments were offered.
- Patients could request to speak to clinicians via the telephone.

People whose circumstances make them vulnerable:

- Double-length appointments were available for patients with a learning disability.
- People in vulnerable circumstances, including homeless patients, were able to register with the practice.

People experiencing poor mental health (including people with dementia):

Staff we interviewed had an understanding of how to support patients with mental health needs and those patients living with dementia. However, published data showed the practice was performing below averages in relation to this patient group.

Timely access to care and treatment

Patients were not able to access care and treatment from the practice within an acceptable timescale to meet their needs.

- Data from the national GP patient survey, relating to results prior to the suspension in May 2018, were below local and national averages, in some cases significantly so.
- Patients with the most urgent needs did not have their care and treatment prioritised consistently.

At our previous inspections, dating back to 2015, it had been consistently evident that patients found contacting the practice by telephone and accessing appointments very difficult. A telephone system, installed in 2015 did not operate effectively to meet patients' needs. We had been told over the course of four inspections that the practice was working with the phone system provider to upgrade

Inadequate

Are services responsive to people's needs?

and improve the system and therefore patient access. At our inspection in May 2018, the practice had told us a new system had been identified with a plan for its installation in September 2018.

At our inspection on 2 October 2018, practice partners told us the system had not yet been installed, the process having been put on hold due to our inspection being announced, despite us receiving feedback from patients that telephone access remained very difficult. Because of the practice's continuing failure to take appropriate action to address this sustained significant issue for patients, we were not assured the practice prioritized improvements to the service.

Listening and learning from concerns and complaints

The practice's complaints handling process did not adequately ensure patients' concerns were appropriately investigated, addressed and learned from.

In May 2018, the records we saw were inadequately documented and did not provide evidence that complaints were handled appropriately and learned from to improve services.

On 2 October 2018, we were shown the same complaints log we had been shown in May 2018, with information still missing. We reviewed the log with the practice manager and found it summarised two complaints, the records of which could not be located. Nothing had been done to improve the complaints handing process, which remained confused and inadequate.

Please refer to the Evidence Tables for further information.

Inadequate

Are services well-led?

We rated the practice as inadequate for providing well-led services following our inspections in August 2017 and May 2018.

We found the delivery of high-quality care was not assured by the leadership, governance or culture in place. Significant issues that threatened the delivery of safe and effective care were not identified or adequately managed. There were low levels of staff satisfaction. There was poor collaboration or co-operation between teams.

We have again rated the practice it as inadequate for providing well-led services because:

- Insufficient action had been taken to address all the concerns noted at our previous inspections.
- Action that had been taken had been implemented by the caretaker practice, with little involvement of the Staunton partners. In our discussion, the partners did not have a clear understanding of the revised processes to provide sufficient assurance they could operate and maintain them effectively to bring about and sustain improvement.
- The practice did not have effective systems or processes in place to support good governance or management and to enable it to assess, monitor and improve the quality and safety of the services being provided.
- We identified significant safety failings which continued to put patients at risk.

Leadership capacity and capability

Leaders were not able to demonstrate they had capacity and skills to deliver high-quality, sustainable care. The practice had failed to take effective action to address historical and ongoing concerns, such as the processes for managing significant events, handling complaints and telephone access.

Vision and strategy

The changes in the partnership, practice management and administrative staff in the past had been wholly disruptive to the service. The handover of duties between practice managers had not been carried out effectively and this remained the case in relation to the new practice manager, who had been appointed in July 2018. The new practice manager had not been given access to all the previous manager's files and could not provide us with all the evidence we requested, such as health and safety risk assessments and staff training. The practice did not have a clear vision and credible strategy to deliver high quality, sustainable care.

- The practice had not planned its services to meet the needs of the practice population.

Culture

The practice did not have a culture of high-quality sustainable care.

- The practice had not focused on the needs of patients.
- There remained some conflict between the staff teams and individuals.

Governance arrangements

Responsibilities, roles and systems of accountability did not support good governance and management.

- Structures, processes and systems were not consistently effective to support good governance and management.
- Practice leaders had not consistently established and implemented proper policies, procedures and activities to ensure safety.

Managing risks, issues and performance

There was a lack of clarity around processes for managing risks, issues and performance.

- Policies and procedures had been in place at our previous inspections, but evidence showed some were not consistently acted on. For example, we found high risk medicines reviews had not been carried out for all patients; and the processes for managing significant events and complaints remained inadequate.
- We saw limited evidence that clinical audit had a positive impact on quality of care and outcomes for patients.
- The practice was not able to provide evidence that all staff were up to date with mandatory training requirements.

Appropriate and accurate information

The practice did not always have appropriate and accurate information.

Inadequate

Are services well-led?

- Staff were still not able to clarify issues we raised about the accuracy of the significant events and complaints logs.
- Most of the 615 outstanding healthcare records we found at our inspection in May 2018 had been merged with those held by the practice to produce a complete and accurate medical history. However, five remained outstanding and importantly no formal protocol had been established by the practice to prevent a recurrence.

Engagement with patients, the public, staff and external partners

The practice did not consistently involve patients, the public, staff and external partners to support high-quality sustainable services.

We met with four members of the PPG. They said the caretaker practice had continued to have meetings with them, some of which were attended by the Staunton partners. However, the latter's involvement had been limited and unproductive. The PPG told us that telephone access to the service and the availability of appointments remained a concern for them.

Continuous improvement and innovation

There was little evidence of systems and processes for learning, continuous improvement and innovation. Process changes made since our previous inspections had been implemented by the caretaker practice, with limited involvement of the [Staunton] partners and we were given little assurance these could or would be sustained by the partners at the practice to bring about the required improvement to services and to reduce risks to patient safety.

Please refer to the Evidence Tables for further information.

This section is primarily information for the provider

Enforcement actions

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. We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** **The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:** • The practice did not have effective systems to keep patients safe and to protect them from risk of abuse or harm. • The practice could not provide evidence that general health and safety risk assessments had been carried out. **There was inadequate safe management of medicines. In particular:** • Clinical audits carried out by the caretaker practice had identified significant issues relating to prescribing practice. **Not all of the people providing care and treatment had the qualifications, competence, skills and experience to do so safely. In particular:** • The practice could not provide evidence that all staff had received mandatory training or appraisals. **The equipment being used to care for and treat service users was not safe for use. In particular:** • The practice could not provide evidence that electrical and medical equipment had been inspected, calibrated and certified safe. Regulation 12 (1)

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Diagnostic and screening procedures

Family planning services

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met:

Systems or processes were not adequate to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

- The system for identifying and managing significant events and for handling patients' complaints remained confused. Staff could not access records for us to review. There was no evidence that clinical audit was driving improvement. For example, an audit carried out in August 2018 had identified the need for further staff training, but this was not programmed before February 2019.
- The practice's results from the national GP Patient survey relating to the service being caring and responsive were below local and national averages, in some cases significantly so.

Systems or processes were not adequate to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:

- The practice could not provide evidence that general health and safety risk assessments had been carried out.

Systems or processes were not adequate to enable the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular:

- No protocol had been established to manage patients' records transferred from other practices, to ensure complete medical histories were maintained.

Systems or processes were not adequate to enable the registered person had maintained securely such records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity or activities. In particular:

- The practice could not provide evidence that all staff had received training or appraisals.

Regulation 17 (1)