The Staunton Group Practice

Quality 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.

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We had previously carried out an announced comprehensive inspection at the Staunton Group Practice on 26 July 2017 and 1 August 2017. We rated the practice as inadequate and it was placed in special measures with effect from 19 October 2017. We identified concerns over safety and governance at the practice. We served warning notices under regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The report of the comprehensive inspection can be found by selecting the 'reports' link for

Staunton Group Practice on our website at http://www.cqc.org.uk/location/1-573879781. The practice sent us a plan of the action it intended to take to meet the requirements of the regulations.

Summary of findings

We carried out this focussed inspection on 8 November 2017 looking at the identified breaches set out in the warning notices, under the key questions Safe, Effective, Responsive and Well-led. At the inspection, we reviewed the action plan and found that the practice had made some improvements sufficient for us to withdraw the warning notices. Further changes were planned for implementation by 31 December 2017. The improvements need to become embedded and a number of issues remain to be addressed, so we have served requirement notices. We have not reviewed the ratings for the key questions or for the practice overall. We will consider the practice's ratings when we carry out a full comprehensive inspection at the end of the period of special measures.

- The practice had reviewed and introduced new systems for handling safety alerts, significant adverse events, and work was ongoing to refine the systems.
- The practice had commenced work on consolidating its records and reviewing procedures relating to child protection and adult safeguarding. The practice would be seeking support and guidance under the special measures arrangements regarding use of appropriate records tools to ensure that patient safety was maintained.
- The practice had introduced a system for monitoring patients' uncollected prescriptions. This needed further review to ensure it operated effectively.
- The practice had re-established a process to monitor patients referred for two-week secondary consultations, but this needed further improvement to be fully effective.
- An infection control audit had been carried out and actions it had identified had been addressed.
- All staff were now up to date with mandatory training requirements and overdue appraisals had been completed.
- The practice had revised its procedures to ensure that clinicians were aware of relevant and current evidence-based guidance and standards.
- The backlogs of documents to be scanned onto patients' records and those in GPs' Docman systems, which we had noted at the comprehensive inspection, had been cleared.
- The practice was recruiting additional clinical staff to improve patients' access to the service. It had appointed two new administrators and was reviewing the appointments system.

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

- Ensure the care and treatment of patients is appropriate, meets their needs and reflects their preferences.
- 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.

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

- Ensure that information is appropriately shared with other healthcare providers.
- Ensure that patients' uncollected prescriptions are monitored on a regular basis.
- Ensure that blank prescription pads and forms are kept securely in accordance with good practice guidelines.
- Continue to review and identify means of improving patients' access to the service.

This practice was placed in special measures on 19 October 2017. The practice will be kept under review and a comprehensive inspection will be carried out at the end of the special measures period. If necessary we shall take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling the registration or to varying the terms of the registration within six months if the practice does not improve. The practice will be kept under review and if needed could be escalated to urgent enforcement action.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?
We have not reviewed the rating for this key question.

Are services effective?
We have not reviewed the rating for this key question.

Are services responsive to people's needs?
We have not reviewed the rating for this key question.

Are services well-led?
We have not reviewed the rating for this key question.

Summary of findings

Areas for improvement

Action the service MUST take to improve

- Ensure the care and treatment of patients is appropriate, meets their needs and reflects their preferences.
- 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.

Action the service SHOULD take to improve

- Ensure that information is appropriately shared with other healthcare providers.
- Ensure that patients' uncollected prescriptions are monitored on a regular basis.
- Ensure that blank prescription pads and forms are kept securely in accordance with good practice guidelines.
- Continue to review and identify means of improving patients' access to the service.

The Staunton Group Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team comprised a CQC inspector and a GP specialist adviser.

Background to The Staunton Group Practice

The Staunton Group Practice (the practice) operates 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 provides NHS primary medical services through a General Medical Services (GMS) contract to approximately 14,500 patients. The practice is part of the NHS Haringey Clinical Commissioning Group (CCG) which is made up of 51 general practices. The practice is registered with the CQC to provide the following regulated activities - Diagnostic and screening procedures, Family planning, Maternity and midwifery services, Surgical procedures, Treatment of disease, disorder or injury. The patient profile for the practice indicates a population of more working age people than the national average, with a high proportion of younger adults in the 20 to 40 age range. There is a lower proportion of older people in the area compared with the national average.

The clinical team is made up of four partner GPs and four salaried GPs. Four of the GPs are female and four male. The partner GPs work between six and nine clinical sessions per week; the salaried GPs between four and nine sessions. The practice uses two regular locum GPs. There is a nurse practitioner, who works six sessions; three nurses, working between two and eight sessions. The practice has one healthcare assistant. It is a training practice, with two doctors in training and a trainee nurse being attached for the coming year. The administrative team comprises a practice manager, an administrative manager, a reception manager and a project manager. There are 15 other staff in the administrative / reception team.

The practice is open between 8.30 am and 6.30 pm, Monday to Friday. It is closed at weekends. Phones are operated between 8.00 am and 6.30 pm, but the practice asks patients to restrict calls between 8.00 am and 11.00 am to urgent calls only.

The practice has 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.

Are services safe?

Our findings

Safe track record and learning

At our comprehensive inspection in August 2017, we had found that the practice's system for reporting and recording significant events did not ensure that events were investigated fully or that learning was shared appropriately. The practice had sent us summary records of five significant events that had occurred in the preceding 12 months, which we reviewed with the partner GPs. The summaries varied in the amount of detail recorded and three did not mention when they should be reviewed or by whom. Administrative staff told us they were not routinely involved in any discussion, even if they had raised the concern in the first instance. The partner GPs we spoke with could not recall two of the significant events the practice had informed us of. Staff told us they did not routinely record new cancer diagnoses as significant events.

At our follow up inspection on 8 November 2017, we saw that the practice had formalised arrangements for monitoring significant events. A log had been introduced and more events from the previous 12 months had been recorded, with the log containing 20 events, including new cancer diagnoses. We saw evidence that the process had been discussed at a practice meeting in October 2017 to inform all staff of future plans. Work was ongoing to consolidate and categorise the significant events records. After the follow up inspection, the practice sent us a revised action plan, with named responsible clinical and administrative leads for each established area for improvement. The practice had identified a document management system for use in processing and monitoring significant events, with plans for its full implementation by 31 December 2017.

At our comprehensive inspection in August 2017, we had found that the process for reviewing safety alerts was not robust. An alert, dated May 2017, related to possible faults with a particular type of defibrillator, had noted actions recorded, but the person responsible for carrying them out had not been informed.

At our follow up inspection in November 2017, we saw that the safety alerts process had been discussed and reviewed at a practice meeting in September 2017. We saw three examples of alerts being disseminated to staff and monthly consolidated updates were now being used to notify staff of alerts; for example the November update listed 10 alerts. The cover form for alerts had been revised, but we noted it was not being completed fully, with any necessary action not being recorded. After the inspection, the practice told us that the form would be revised further and simplified. The practice would use the document management system it had identified to handle safety alerts, with full implementation by the 31 December 2017, and had programmed reviews of the process for 31 January and 31 March 2018.

Overview of safety systems and processes

At our comprehensive inspection in August 2017, we had found that training records were not able to confirm that all staff, including the clinical leads for safeguarding, had up to date safeguarding training to the appropriate level. We noted that 11 members of the clinical team were overdue training relating to mental capacity and consent. Staff members were not able to demonstrate that appropriate safeguarding coding was used on patient records or whether pop up alerts would notify staff of any ongoing concerns. Staff members were not aware of whether information was shared with the local out-of-hours care provider.

At our follow up inspection in November 2017, we saw evidence that all staff had undertaken safeguarding training appropriate to the roles and the clinical team had received fresher training in mental capacity and consent. The practice had reviewed its safeguarding policies. Work had commenced on reviewing patient records and consolidating the practice's registers of vulnerable children, children in need and those on protection plans, together with the register of vulnerable adults. Staff were in the process of reviewing the records to identify historical concerns and were contacting social services for up to date information. The practice's revised action plan stated this would be complete by 30 November 2017. We discussed records coding and staff told us the practice used the system followed by all practices within the CCG. However, it was apparent that there were still issues regarding appropriate pop up alerts to inform staff of ongoing concerns. GP partners told us it would seek support and guidance under the special measures arrangements to review the process. The revised action plan stated this would be completed by 31 December 2017. Partner GPs showed us the standard information sharing form used by the local out-of-hours provider. It included the requirement

Are services safe?

for practice staff to contact the out-of-hours provider to confirm the information had been received. We looked at several completed examples, but noted the relevant section had not been filled in to show that the confirmation of receipt had been obtained.

At our comprehensive inspection in August 2017, we had found some work surfaces in treatment rooms were cluttered, making cleaning more difficult. In one consultation room, we found an unsealed sharps bin, used for disposing needles, was filled over the recommended half-way level and was not signed and dated to record when it was set up. In another room, we saw another unsigned and undated sharps bin. Curtains in consultation rooms were dated when they were put up. We found one that had been dated September 2016, which ought to have been changed after six months, in accordance with infection prevention and control guidance. There had been no infection prevention and control audit carried out since January 2016. The practice had a legionella management plan, but the task log associated with it was not complete and there was no evidence that the tasks had been done. Training records indicated 12 members of the clinical team and six members of the administrative team had not received up to date infection prevention and control training.

At our follow up inspection in November 2017, we found that all work surfaces were clear, but we saw another sharps bin that was near-full. All sharps bins had been signed and dated and curtains were clean and had been in place less than six months. An infection control audit had been carried out in October 2017 and the two required actions it had identified had been addressed. Logs confirmed that tasks necessary under the legionella management plan had been carried out by a contractor during visits made in August, September and October. Records showed all staff were now up to date with infection prevention and control training.

In August 2017, at our comprehensive inspection, we had found the arrangements for managing medicines were not sufficiently robust to ensure patient safety was maintained. There was no process for monitoring prescriptions left uncollected by patients. Some prescription pads and forms were not kept securely in accordance with good practice guidelines, some being accessible in unlocked consultation rooms.

In November 2017, at the follow up inspection we saw that a process of monitoring uncollected prescriptions had been introduced. However, it was not sufficiently robust. The prescriptions box was being monitored on a monthly basis and any prescriptions left uncollected for three months were brought to the prescriber's attention. We checked two repeat prescriptions against the patients' prescribing records. In one case, a monthly repeat prescription had been awaiting collection since 19 October. The patient's previous prescription had been issued in July, but there had been none issued in August and September. This indicated that the patient had not been receiving their medication in accordance with their prescribing plan. The other patient had a repeat prescription awaiting collection for a week. However, they had not collected their previous prescription from September. Neither of these cases had been noted and checked by staff. GP partners stated that they would review the process to establish more frequent and effective monitoring and will be seeking guidance and support under the special measures arrangements. We also noted some improvement with prescription security, with loose forms in printers being logged and monitored. However, we saw several prescription pads that had not been logged in accordance with good practice guidelines.

Monitoring risks to patients

At our comprehensive inspection in August 2017, we had found that most staff members had no record of receiving fire safety training. At our follow up inspection we saw evidence that all staff were now up to date with this training.

At our comprehensive inspection in November 2017, we saw several unoccupied consultation rooms were left unlocked and staff had left their smartcards inserted in the computer terminals, increasing the possibility that unauthorised persons might be able to access patients' medical records. At the follow up inspection we noted that the practice protocol had been revised and staff had been reminded of issues over information security. We found that the unoccupied rooms were locked and those we checked had no smartcards in the terminals.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

In August 2017, at our comprehensive inspection, we had found there was not an effective process to ensure that clinicians were aware of relevant and current evidence-based guidance and standards, including NICE best practice guidelines. Staff told us that one of the partner GPs was responsible for reviewing new guidance and disseminating it to colleagues. However, the process was described as "hit and miss" by one of the partner GPs we spoke with.

In November 2017, at our follow up inspection, we saw that work had commenced with reviewing the process and this was ongoing. We were shown evidence of four sets of guidance being reviewed and discussed at a practice meeting in October. The revised action plan included steps to sign up to the NICE newsletter to raise awareness of NICE guidance that had been issued and that which is in development. All current guidance and quality standards would be discussed at clinical meetings, with the process being fully implemented by 30 November. The revised process was to be monitored and reviewed again in January and March 2018.

Co-ordinating patient care and information sharing

At our comprehensive inspection in August, we had found a large volume of papers, correspondence and test results that we were told was waiting scanning onto patients' records. These numbered approximately 5,000 and dated between 2015 and October 2016, when the practice had started using a new clinical computer system and when the administrative team had been re-organised and new working practices had been introduced. Although many of the documents were annotated as having been checked by GPs and actioned, a significant number contained no evidence of having been reviewed. We saw internal correspondence dating from November 2016 regarding plans for staff to work at weekends to deal with the scanning backlog, but the arrangements were finalised too late for many staff to attend. We also found a total of 1,779 documents, including test results, in various GPs' Docman Workflow systems, used to transmit documents electronically, which had not been marked as read.

The practice had informed us of progress with dealing with the backlog of scanning following our comprehensive inspection. In November, at the follow up inspection, it was confirmed that the backlog had been dealt with. This had taken three weeks, with staff coming in at weekends. The GPs' Docman systems had also been cleared to acceptable levels, with most being empty. One GP partner had eight items in the system, which had come in over the previous few days. Another GP partner had 18 items. The GP partner was not available to speak with us. However, others told us the documents had been reviewed, but it was the GP partner's practice to leave some documents on the system for further follow up. We noted that in two of these cases, an urgent referral and a blood test, had taken two weeks to address. The GP partners agreed to look into these and discuss with the GP partner concerned. The practice confirmed after the follow up inspection that both these issues had been addressed.

In August 2017, at our comprehensive inspection, we were told that prior to the administrative re-organisation, a named staff member had maintained a central log of patients referred for two-week secondary consultations to investigate possible cancer symptoms. Since October 2016, the responsibility for monitoring the referrals was to have been shared between the various teams. However, administration staff told us that the monitoring was not being done, as training had not been provided. The practice has reinstated the use of the original monitoring spreadsheet after our first visit.

In November 2017, at our follow up inspection, staff told us that the process had been reviewed and we saw that a new monitoring spreadsheet had been introduced. There was a staff rota to cover the daily monitoring and updating, replacing the previous arrangement under which a named member of the administrative staff had been responsible. We discussed the effectiveness of the new system, having noted that the new spreadsheet was more complex than before. It used a red / amber / green colour coding process intended to make monitoring easier. However, we saw that there were a number of errors with the colour coding that compromised effective monitoring and which had not been noted by staff. The GP partners agreed to address this as part of the ongoing process review, set out in the practice's action plan.

Effective staffing

At our comprehensive inspection in August 2017, we saw that the practice had a detailed training protocol. However, we found it was not being followed. Some elements of

Are services effective?

(for example, treatment is effective)

training, including overdue refresher courses, had not been undertaken since our last inspection in May 2016. We noted examples such as training in infection prevention and control, safeguarding, fire safety and capacity to consent to treatment. New ways of working had been introduced following the re-organisation of administrative functions in October 2016. A number of small teams had been set up, each working to a number of GPs. However, staff told us that training had not been sufficient to enable them to carry out their new responsibilities effectively. Annual appraisals for non-clinical staff were overdue by three months.

At our follow up inspection in November, we saw evidence that all staff were up to date with mandatory training and that the overdue staff appraisals had been completed. We noted from staff members' comments on the appraisal forms, that they were more positive regarding developments at the practice since our comprehensive inspection. The review of the administrative functions was ongoing and GP partners told us there was a separate exercise to carry out a skills analysis and to review staff members' future training needs. They showed us a form that had been developed for this process and which would be put to use in the near future.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Access to the service

In August 2017, at our comprehensive inspection, we had found that the practice did not always meet patients' needs. 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. Published data from the GP patient survey showed that patient satisfaction with access to the service was significantly lower than local and national averages and most figures were worse than in 2016. There had been no improvement made since our inspection in August 2015.

At the follow up inspection in November, we saw that the practice was monitoring responsive aspects of the service. The concerns and the need to improve had been discussed and reviewed with all staff at practice meetings and we saw from comments on appraisal forms that staff members were engaging in the process. GP partners told us that the practice had attempted to recruit a salaried GP earlier in the year, but had not been successful. However, efforts at recruiting would continue. Funding for additional staff had been identified. The CCG was assisting with the appointment of an in-house pharmacist and two more administrative staff had been recruited and would be starting work shortly. The practice also had plans to appoint a nurse practitioner in the near future. The action plan submitted by the practice included a review of the doctors' rota, of the ratio of available routine and urgent appointments available, and improving the management of appointments which patients failed to attend. The target date for implementing any revised procedures was 31 December 2017.

Are services well-led?

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

Our findings

Vision and strategy

At our comprehensive inspection in August 2017, we saw that the practice had a written mission statement, but we found there were no detailed or realistic plans to achieve this. Staff members were not fully aware of their own roles and responsibilities. This had led, for example, to the practice's monitoring process of patients' two-week referrals to lapse.

In November 2017, at the follow up inspection, GP partners told us the practice was planning to make use of support and guidance from the special measures team to establish suitable business plans and appropriate governance processes. The practice had engaged with the CCG, the Royal College of General Practitioners (RCGP) and the Local Medical Committee. Its first meeting with the RCGP was scheduled for 1 December 2017. There had been several staff meetings to establish how performance could be improved. The practice had produced a "Quality Improvement Strategy" which had been discussed with staff at a meeting in October 2017. The practice's action plan stated that the strategy would be adopted fully by 14 November 2017.

Leadership and culture

At the August 2017 comprehensive inspection, several staff members said morale was very low. Changes intended to improve performance and governance had been introduced without sufficient consultation, planning and training being provided. Relations, collaboration and co-operation between the teams were poor. This was conceded by partner GPs, who told us that efforts were continuing to improve staff relations and working practices. The practice had engaged a consultancy in March 2017, but there had been little progress. Although staff told us they were able to raise concerns and suggestions regarding possible improvements, they did not feel confident that they would be acted upon effectively.

At our November follow up inspection, we saw that work with the consultancy was becoming more effective and that guidance and support was being provided. We saw from staff meeting minutes that all staff had been involved in discussions regarding our concerns from the last inspection. Feedback noted on staff appraisal forms was more positive, with staff stating they were involved in the improvement process. Staff members we spoke with said morale was improving. The practice's administrative systems and processes were being reviewed and some changes had been introduced. However, these changes need to become embedded to be fully effective and further work was needed. The GP partners said the practice it would actively seek and act upon guidance and assistance from the special measures support team and its consultants.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

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 **The registered persons had not done all that was reasonably practicable to identify and mitigate risks to the health and safety of service users receiving care and treatment. In particular –** • The registered persons did not ensure there was a system in place to identify and support vulnerable children and adults and ensure safeguards were in place. For example, staff were not able demonstrate that all vulnerable patients could be identified on the clinical system to ensure that staff at the practice were able to carry out safeguarding responsibilities. Staff could not demonstrate that information was shared appropriately. • There were not effective arrangements to ensure the proper and safe management of medicines. For example, systems did not ensure that uncollected prescriptions were monitored effectively and that patients' care was reviewed appropriately. **This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
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 **There were ineffective systems or processes to enable the registered persons to assess, monitor and improve the quality and safety of the services being provided. For example –** • There was not a robust process to ensure that clinicians were aware of relevant and current evidence-based guidance and standards. Arrangements for actioning

This section is primarily information for the provider

Requirement notices

safety alerts and implementing relevant guidance, and for reviewing significant events, were not robust. The monitoring of patients referred for two-week secondary consultations was not sufficiently effective.

- Published data from the GP patient survey showed that patient satisfaction with access to the service was significantly below average. There had been no improvement made since our inspection in August 2015. Robust plans to achieve improvement had not yet been established and implemented.

This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.