Drs Masterton, Thomson, Bolade & Otuguor

Quality Report

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

Ratings

Overall rating for this service	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services well-led?	Requires improvement

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Drs Masterton, Thomson, Bolade & Otuguor on 26 July 2016. During the inspection we identified breaches of regulation 12 (Safe Care and Treatment), regulation 17 (Good governance) and regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches resulted in the practice being rated as inadequate for being safe, effective and well-led and good for being caring and responsive. Consequently the practice was rated as inadequate overall.

The specific concerns identified were:

- There was not always evidence of learning from significant events and not all staff were involved in significant event discussion.
- Satisfactory recruitment checks had not been undertaken for all staff prior to employment.
- The practice's supply of oxygen had expired.
- Systems and processes did not operate effectively to ensure that patients were safeguarded from abuse.
- Infection control risks were not adequately assessed or addressed.
- Medicines were not always managed safely in that high risk medicines were not always monitored appropriately, two of the practice's Patient Group Directions had expired, emergency medicines and prescriptions were not stored securely and vaccines were not being monitored appropriately.
- The practice had not complied with the recommendations in their last fire risk assessment.
- Partners in the practice had failed to ensure that effective systems were in place for the management of test results and to ensure a failsafe system for referrals for urgent tests and assessments.
- Some practice policies were incorrectly dated, did not contain all requisite information, were not regularly reviewed and were not easily accessible to staff.
- There was no system to ensure all staff were regularly appraised.
- Training had not been completed by all staff.
- There were insufficient numbers of clinical staff.

Summary of findings

The practice provided the Care Quality Commission (CQC) with an action plan within 48 hours of the inspection which detailed the action the practice intended to rectify some of the concerns identified on the day of the inspection.

Due to delay on the part of CQC in producing a finalised report from the inspection undertaken on 26 July 2016 and the significant patient safety concerns identified, we undertook a focused inspection of the practice in order to ascertain whether or not the provider had taken the necessary action to address the concerns raised. The current overall rating for this practice is an aggregation of the ratings for caring and responsive in the report from the inspection undertaken on 26 July 2016 and the rating for safe, effective and well led in this inspection report which focused on these key questions. You can read the report from the first comprehensive inspection by selecting the 'all reports' link for Drs Masterton, Thomson, Bolade & Otuguor on our website at www.cqc.org.uk.

Had CQC found that the practice were still inadequate for any key question during this inspection the service would have been placed in special measures for a period of six months after which time a further inspection would have been undertaken to see if sufficient improvement had been made.

An announced focused inspection was undertaken on 1 December 2016. This report focuses on the action that the practice has taken to address the concerns identified during our initial inspection.

Overall the practice is rated as requires improvement. Specifically, following the focussed inspection we found the practice to be requires improvement for providing safe, effective and well led services. This recognises the significant improvements made to the quality of care provided by this service. Our key findings across all the areas we inspected were as follows:

- There was an effective system in place for reporting and recording significant events and lessons were shared to make sure action was taken to improve safety in the practice.
- The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse although most staff had yet to receive child and adult safeguarding training.
- The practice had undertaken appropriate recruitment checks for newly appointed staff but had yet to receive a Disclosure and Barring Service check for the practice healthcare assistant.
- The practice had introduced effective systems to manage results from secondary care and there was evidence of regular multidisciplinary meetings.
- The practice had not implemented the recommendations from their fire risk assessment and there was no effective lead for infection control. All other infection control concerns had been addressed.
- There were sufficient numbers of staff to meet patient need.
- Concerns around high risk drug monitoring had been addressed. However, the practice healthcare assistant was administering medicines in line with Patient Group Directions and not Patient Specific Directions or prescriptions in accordance with current legislation.
- The practice had effective systems in place to deal with emergencies.
- Most staff had still not been appraised within the last 12 months.
- Policies had been updated, contained all necessary information and were accessible to all staff.

The areas where the provider **must** make improvement are:

- Ensure that medicines administered by a healthcare assistant are done so in accordance with a valid Patient Specific Direction.
- Ensure that the practice has an infection control lead that is adequately trained for the role and that all staff are aware of this person.
- Ensure all staff have completed all necessary training in accordance with current legislation.
- Ensure that all staff are regularly appraised.

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

Summary of findings

- Review the high exception rates for those with atrial fibrillation and chronic obstructive pulmonary disease to ensure that all exemptions are appropriate.
- Continue efforts to ensure that staff feel valued.

The findings of this report should be read in conjunction with the findings detailed in the report from our initial inspection conducted on 26 July 2016

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?

Requires improvement

The practice is rated as requires improvement for providing safe services.

- The practice had not implemented the recommendations from their fire risk assessment and there was no designated lead for infection control.
- The practice healthcare assistant was administering medicines in line with Patient Group Directions and not Patient Specific Directions or prescriptions in accordance with current legislation.
- There was an effective system in place for reporting and recording significant events and lessons were shared to make sure action was taken to improve safety in the practice.
- The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse although most staff had still to receive child and adult safeguarding training.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services.

- There was an action plan in place to ensure that staff completed all training and that appraisals were completed annually. However, most staff had not been appraised within the last 12 months and the majority of staff had not completed child or adult safeguarding training.
- The practice had introduced effective systems to manage results from secondary care and there was evidence of regular multidisciplinary meetings.
- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average, although exception reporting for atrial fibrillation and chronic obstructive pulmonary disease was higher than local and national averages.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led.

- The practice had taken action to address some of the deficiencies identified at the last inspection. However, there were a number of areas including medicines management, fire safety and arrangements for training and staff appraisals which had not been addressed.

Summary of findings

- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- All staff felt supported and most felt valued.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people
The practice rating has been changed from inadequate for safe, effective and well led to requires improvement for all three key questions. Consequently the practice are now rated as requires improvement overall. The issues identified as requiring improvement overall affected all patients including this population group.

Requires improvement

People with long term conditions
The practice rating has been changed from inadequate for safe, effective and well led to requires improvement for all three key questions. Consequently the practice are now rated as requires improvement overall. The issues identified as requiring improvement overall affected all patients including this population group.

Requires improvement

Families, children and young people
The practice rating has been changed from inadequate for safe, effective and well led to requires improvement for all three key questions. Consequently the practice are now rated as requires improvement overall. The issues identified as requiring improvement overall affected all patients including this population group.

Requires improvement

Working age people (including those recently retired and students)
The practice rating has been changed from inadequate for safe, effective and well led to requires improvement for all three key questions. Consequently the practice are now rated as requires improvement overall. The issues identified as requiring improvement overall affected all patients including this population group.

Requires improvement

People whose circumstances may make them vulnerable
The practice rating has been changed from inadequate for safe, effective and well led to requires improvement for all three key questions. Consequently the practice are now rated as requires improvement overall. The issues identified as requiring improvement overall affected all patients including this population group.

Requires improvement

Summary of findings

People experiencing poor mental health (including people with dementia)

The practice rating has been changed from inadequate for safe, effective and well led to requires improvement for all three key questions. Consequently the practice are now rated as requires improvement overall. The issues identified as requiring improvement overall affected all patients including this population group.

Requires improvement

Drs Masterton, Thomson, Bolade & Otuguor

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector**.** The team included a Regional GP specialist adviser and a CQC Head of Inspection.

Why we carried out this inspection

We undertook a focussed inspection of Drs Masterton, Thomson, Bolade & Otuguor on 1 December 2016. This is because the service had been identified as not meeting some of the legal requirements and regulations associated with the Health and Social Care Act 2008 during our inspection of 26 July 2016. The regulatory requirements the provider needs to meet are called Fundamental Standards and are set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We had found that some of these requirements had not been adhered to. Specifically:

- There was not always evidence of learning from significant events and not all staff were involved in significant event discussion.
- Satisfactory recruitment checks had not been undertaken for all staff prior to employment.
- The practice's supply of oxygen had expired.
- Systems and processes did not operate effectively to ensure that patients were safeguarded from abuse.
- Infection control risks were not adequately assessed or addressed.
- Medicines were not always managed safely in that high risk medicines were not always monitored appropriately, two of the practice's PGDs had expired, emergency medicines and prescriptions were not stored securely and vaccines were not being monitored appropriately.
- The practice had not complied with the recommendations in their last fire risk assessment.
- The arrangements in place to monitor and act on risk were ineffective in respect of staff recruitment, infection control, management of medicines and emergencies.
- Partners in the practice had failed to ensure that effective systems were in place for the management of test results and to ensure a failsafe system for referrals for urgent tests and assessments.
- Some practice policies were incorrectly dated, did not contain all requisite information, were not regularly reviewed and were not easily accessible to staff.
- There was no system of appraisal for all staff.
- Training had not been completed by all staff.
- There were insufficient numbers of clinical staff.

This inspection was carried out to check that improvements to meet legal requirements planned by the Practice after our comprehensive inspection on 26 July 2016 had been made. We inspected the practice against three of the five questions we ask about services: is the service safe? Is the service effective? Is the service well-led?

Requires improvement

Are services safe?

Our findings

We carried out a comprehensive inspection of Drs Masterton, Thomson, Bolade & Otuguor on 26 July 2016. The practice was rated overall as inadequate but requires improvement for providing safe services. Our inspection identified the breaches of Regulation 12 Safe Care and Treatment, 17 Good Governance and Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches impacted on the practice's ability to provide services that were safe in that:

- There was not always evidence of learning from significant events, not all staff were involved in significant event discussion and the practice's significant event policy had not been updated since 2011.
- Satisfactory recruitment checks had not been undertaken for all staff prior to employment. For instance we found that Disclosure and Barring Service checks had not been completed for all staff prior to employment and that appropriate references were not always collected for all staff.
- Systems and processes did not operate effectively to ensure that patients were safeguarded from abuse as the child safeguarding policy did not contain details of external contacts, staff we spoke with were not able to easily access the practice's safeguarding policy and most members of staff had not completed up to date child and adult safeguarding training.
- Infection control risks were not adequately assessed or addressed. For example we found reusable equipment in one of the clinical rooms and the practice were not able to explain why it was there. We identified infection control concerns in the staff toilets. There were damaged chairs in the patient waiting area and a torn clinical couch which posed an infection control risk.
- Medicines were not always managed safely in that high risk medicines were not always monitored appropriately, two of the practice nurse's Patient Group Directions had expired, emergency medicines and prescriptions were not stored securely and vaccines were not being monitored appropriately.
- The practice had not complied with the recommendations in their last fire risk assessment.
- The arrangements in place to monitor and act on risk were ineffective in respect of emergencies as the practice did not have a children's oxygen mask, the oxygen cylinder had expired and not all staff had received basic life support training.
- There were insufficient numbers of clinical staff.

During the inspection undertaken on 1 December 2016 we found that the practice had made improvement since our last inspection on 26 July 2016. However we identified areas where additional action needed to be taken:

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Since the last inspection the practice had introduced a new significant event policy and significant event analysis was now a standing agenda at all practice meetings.
- Staff told us they would inform their line manager or the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- Since our last inspection there had been no clinical significant events though we were shown four related to administrative error or oversight. We saw that discussions had taken place with those staff directly involved in the significant event. We were told that an annual review involving all staff would be undertaken of all significant events from the previous year to identify patterns and trends.
- The practice carried out a thorough analysis of these significant events and action was taken to improve safety and ensure that similar incidents did not occur in the future. For example, we reviewed one significant event which related to lack of medical indemnity insurance for one of the practice partners. Once the practice had identified that this partner did not have medical indemnity insurance in place, they were

immediately withdrawn from clinical practice. The practice implemented a thorough review and monitoring system in response to the event to ensure that adequate indemnity arrangements are in place for all staff. The practice has since provided evidence that the partner has now obtained cover and that the insurance provider has agreed to supply retrospective cover for the period of time that they were uninsured.

Overview of safety systems and processes

We found that there were some systems, processes and practices in place to keep patients safe and safeguarded from abuse however some risks did remain as most staff had still not received adequate safeguarding training, there was no effective infection control lead in place and the practice healthcare assistant was not administering medicines in accordance with current legislation and guidance:

- The practice had updated its safeguarding children policy to include contact information for external safeguarding leads. This was provided to the Care Quality Commission (CQC) shortly after the last inspection. Many of the practice staff still had not completed child and adult safeguarding training. The practice had provided a timetable shortly after our initial inspection which confirmed that all training, including safeguarding, would be completed by all members of staff by January 2017. We were provided evidence after the inspection that this had now been completed. Staff that we spoke to were able to outline what may constitute a child protection or adult safeguarding concern and how they would escalate any safeguarding concerns. Staff were able to access both safeguarding policies on the practice's share drive. Alerts were in place for patients where safeguarding concerns had been identified.
- Though we identified one area of infection control concern on the day of our inspection the practice had addressed all of the infection control risks identified at the previous inspection and appropriate standards of cleanliness and hygiene were maintained in all other areas of the practice. The practice nurse had left since our last inspection and the practice had designated their newly appointed healthcare assistant as the lead in the interim. However the healthcare assistant was not certain if they had been appointed to this role and some staff did not know the identity of the infection control lead. The practice was clean and tidy in all areas and we were provided minutes of a practice meeting after our inspection where the identity of the infection control lead was discussed. All staff had now completed up to date infection control training.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe in most areas (including obtaining, prescribing, recording, handling, storing, security and disposal). However there were still some concerns which required further action to be taken. The practice had undertaken a review of high risk medicines used to treat rheumatoid arthritis since our last inspection we saw evidence that all but three of these patients now had shared care agreements in place. For the three patients who did not have an agreement in place there was evidence that the practice had repeatedly contacted the secondary care provider for clarification regarding who should be monitoring these patients. The practice had employed a pharmacist since the last inspection. As an independent prescriber the pharmacist was responsible for undertaking medication reviews and assisted with medicines reconciliation. We identified during our last inspection that the temperature of the practice's vaccine fridge had gone out of range on several occasions. There was no evidence to suggest that this was raised with the practice partners during the last inspection. We found that no action had been taken in response to the elevated fridge temperatures since our last inspection. However when we asked staff what they would do in the event that vaccine fridge temperatures went outside of the optimum range and were assured by the answers provided that the practice had systems and processes in place to ensure legislation and guidelines were followed. The practice told us that they would investigate the raised fridge temperatures and take appropriate action if necessary. Additionally the practice provided us with a copy of a written protocol for vaccines, detailing what to do in the event that fridge temperatures went out of range after our inspection. The practice also informed us after the inspection that they had taken advice regarding the increased fridge temperatures from the CCG pharmacist. The practice health care assistant was administering medicines in accordance with a Patient Group Direction (PGDs are written instructions which enable nurses to supply or administer medicines to groups of patients who may

not be individually identified before presentation for treatment) instead of a Patient Specific Direction (PSDs are written instructions, signed by an authorised prescriber for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis) in accordance with legislative requirements. We informed the practice on the day and were told that PSDs would be implemented for any medicines administered by the health care assistant in the future and were sent copies of PSDs that the practice were using after the inspection.

- We reviewed two personnel files for the most recently appointed members of staff and found most of the appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. The practice had yet to receive a Disclosure and Barring Service check for the healthcare assistant. However, we saw that the information had been requested prior to employment.

Monitoring risks to patients

It was evident that the practice had taken action to address risks associated with staffing

- Though one of the partners had taken a sabbatical and the practice nurse had left, the practice had put arrangements in place to ensure that there were adequate staff in place to meet patient need. Two long-term locum GPs were being used to cover staff shortages and one of the retired partners continued to work where needed. The practice had obtained the services of an agency with the aim of covering 10 clinical sessions. The practice anticipated that all of these sessions would be covered by agency staff by December 2016. The practice demonstrated efforts made to recruit a practice nurse but were finding this difficult. The practice had recruited a pharmacist and a healthcare assistant in addition to a locum nurse. The healthcare assistant was competent to undertake some of the duties of the practice nurse and the locum nurse was able to fulfil all tasks outside of the healthcare assistant's competence. The practice pharmacist was able to prescribe for patients and complete medicine reviews. All staff we spoke with on the day of the inspection told us that staffing was adequate

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents.

- Since our last inspection the practice had purchased a defibrillator, child oxygen masks and had replaced the expired oxygen cylinder. Proof that these items had been ordered was provided within 48 hours of our initial inspection and we saw that this was in place on the day of this inspection.
- All staff had received basic life support training within the last 12 months.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At the last inspection completed on 26 July 2016 the practice was rated as inadequate for providing effective services.

On the inspection completed on 26 July 2016 we found that that the practice was in breach of regulation 18 staffing and 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as:

- Not all staff had completed all essential training including safeguarding, fire safety awareness, basic life support, information governance and infection control.
- Most staff had not received an annual appraisal.
- The processes in place for receiving, reviewing and taking action in response to test results from secondary care organisations did not keep patients safe.

In addition to the breaches of regulation we found that:

- The practice had higher exception reporting rates for patients with chronic kidney disease and cancer. Exception reporting is the removal of patients from Quality Outcomes Framework (QOF) calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects. QOF is a system intended to improve the quality of general practice and reward good practice.
- The practice did not have systems in place to ensure locum staff working at the practice had all necessary information to enable them to work effectively.
- There was a lack of evidence of regular multidisciplinary working and clinical meetings.
- A member of staff we spoke with was not fully aware of current legislation and guidance for assessing capacity and obtaining consent from children and young people.

During the inspection undertaken on 1 December 2016 we found that the practice had made improvement since our last inspection on 26 July 2016. However we identified areas where additional action needed to be taken:

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). Results for 2015/16 had been published since our last inspection The most recent published results were 99% of the total number of points available. Exception reporting was 13% which was above the national average of 9.2%. This was the same as performance in 2014/15.

We found that there had been improvement in respect of performance for some clinical indicators between the two QOF years but that attainment had reduced in other areas:

We saw a reduction in exception reporting for cancer which had reduced from 31% in 2014/15 to 19% in 2015/16 which was 3% lower than the local average and 6% lower than the national average.

Chronic kidney disease had not been included in the 2015/16 QOF.

The practice's overall exception reporting rate for patients with atrial fibrillation was 16% compared with 7% in the CCG and nationally. This had improved from 21% in 2014/15. The practice were aware that they were an outlier in this area and told us that clinical staff were working with the practice pharmacist to review patients with atrial fibrillation to ensure that patients were prescribed anticoagulation medicine where appropriate.

Exception reporting for patients with chronic obstructive pulmonary disease (COPD) was higher than local and national averages 31% compared to 10% in the locality and 13% nationally. This was higher than the practice's 2014/15 rate of 26%. Staff told us that this was higher due to the number of patients on their list currently living in care homes who were too frail to participate in COPD assessments.

We reviewed a sample of records of patients with these conditions and found that all exceptions were either clinically justifiable or the result of a coding error.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

Requires improvement

Are services effective?

(for example, treatment is effective)

- The practice had created a locum pack which provided essential information for locum staff working in the practice.
- The practice provided a training programme within 48 hours of our last inspection which indicated that all training including child and adult safeguarding, information governance, basic life support, infection control and fire safety training would be completed by the end of January 2017. We reviewed staff files on this inspection and found that all infection control, fire safety, information governance training had been completed in line with the timeframes set out in the action plan. Adult safeguarding training had been scheduled for December 2016 and child safeguarding for January 2017.
- We found at the last inspection not all staff were receiving regular appraisals. The practice told us at this inspection that not all staff had received an annual appraisal but staff had been informed that this needed to be completed by March 2017.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- The practice submitted an action plan within 48 hours of our last inspection which stated that all outstanding abnormal results would be actioned within two working days of the inspection. The practice had since introduced a comprehensive protocol for the management of pathology results. All urgent test results now need to be dealt with within two working days of receipt, and non-urgent results within five working days. Tasks related to urgent pathology results, for example booking a follow up appointment, would be dealt with by reception staff on the day that they were sent to them. Other tasks had to be dealt with within two working days. Given the staffing arrangements all clinicians are "buddied" with one another to ensure that test results are reviewed and actioned during staff absence. There was a designated administrator who was responsible for checking each clinician's pathology inbox on a daily basis and flagging any results to clinicians which had not been progressed within the stated timescales. If this administrator identified that outstanding results had not been dealt with the matter would be escalated to the practice manager who would hold discussions with the clinicians in question and notify the other partners. We found that results were being managed in accordance with this policy during our inspection visit.
- The practice scheduled multidisciplinary meetings with community matrons, district nurses and health visitors and we saw evidence of meetings where complex patients had been discussed and plans for treatment updated.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

Are services well-led?

Requires improvement

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

Our findings

At the last inspection completed on 26 July 2016 the practice was rated as inadequate for providing well led services.

Many of the regulatory breaches outlined under the safe and effective domains during our inspection of 26 July 2016 indicated a lack of governance and effective systems and processes. Lack of effective systems and processes amounted to a breach under regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as:

- Systems and processes did not operate effectively or keep patients safe; for instance systems to safeguard vulnerable people and manage test results.
- Policies were either incorrectly dated or did not contain all the required information.
- Risk was poorly managed for instance we found that adequate recruitment checks were not always completed prior to staff being appointed and infection control risks were not properly assessed or addressed. We also found that medicines were not always managed safely and the practice did not have satisfactory arrangements in place to enable staff to respond effectively in an emergency.
- Lack of adequate staffing, high workloads and lack of time meant that senior staff did not have time to provide the leadership and support required.
- The practice had not done enough to ensure that staff always felt valued supported and respected. There was an accepted lack of recognition of good staff performance and few staff received annual appraisals.

During the inspection undertaken on 1 December 2016 we found that the practice had made improvement since our last inspection on 26 July 2016. However we identified areas where additional action needed to be taken:

Governance arrangements

Action taken since the last inspection had strengthened the practice's governance framework which had improved patient safety, yet there were still areas in which improvements were needed:

- The practice had implemented an effective system for monitoring pathology results and improving processes around safeguarding. However medicines were still not always being managed in accordance with legislation and guidance as the practice healthcare assistant was not administering medicines in accordance with a valid Patient Specific Direction. Although an action plan was in place to address these issues, staff at the practice had still not all completed safeguarding training or received an appraisal.
- The practice had still not taken action to mitigate fire safety risks as recommended in their 2014 fire risk assessment.
- Although staff roles were clear in most areas, the lead for infection control was not aware that they held responsibility in this area and staff we spoke with were also not aware of who the lead was.
- The practice manager had undertaken a review of policies and procedures in the practice. We reviewed a range of practice policies and found that they contained relevant information including review dates and were easily accessible to all staff.

Leadership and culture

On the day of inspection the partners in the practice demonstrated that they had used the feedback provided by the Care Quality Commission to draft a detailed action plan which sought to address all of the concerns identified at the last inspection to ensure that care provided was safe. Staff told us the partners were approachable and took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

Staff felt supported by management.

- Staff told us the practice held regular team meetings and we saw evidence to support this.

Are services well-led?

Requires improvement

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

- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues and felt confident in doing so.
- Staff said they felt supported, able to raise concerns when they needed to and that everyone in the practice worked well as a team. However one member of staff said that they did not feel valued or appreciated.

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 **How the regulation was not being met:** • The practice health care assistant was administering medication despite no Patient Specific Direction being in force to lawfully authorise her to do so • The practice did not have an effective infection control lead. 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 The registered person did not ensure that the regulated activities at Drs Masterton, Thomson, Bolade & Otuguor were compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **How the regulation was not being met:** Systems and processes did not operate effectively to ensure that risks to health, safety and welfare of service users stemming from: • staff recruitment • safeguarding • infection control • management of medicines Were assessed monitored and mitigated

This section is primarily information for the provider

Requirement notices

This was in breach of regulation 17 (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 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** • There was no evidence that staff were receiving regular appraisals. • Not all members of staff had received the appropriate level of safeguarding training as is necessary to enable them to carry out the duties they are employed to perform This was in breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.