

Woden Road Surgery

Quality Report

The Surgery
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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		Good	
Are services safe?		Requires improvement	
Are services effective?		Good	
Are services caring?		Good	
Are services responsive to people's needs?		Good	
Are services well-led?		Good	

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 Woden Road Surgery on 15 August 2016. The practice is rated as good for providing effective, caring, responsive and well-led services but requires improvement for providing safe services. Overall, the practice is rated as good.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Information about safety was recorded, monitored, appropriately reviewed and addressed. However, although significant events were actioned immediately, there was a long period before the outcome and learning from these was shared with staff.

- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks and the management of high risk medicines.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had received training appropriate to their roles to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- The majority of patients said they were treated with compassion, dignity and respect. However, patients had concerns about the lack of confidentiality in the reception area.
- Information about the services offered and how to make a complaint was available and easy to understand. Patients expressed concerns about the method used to record verbal complaints, as it did not ensure patient confidentiality.
- Patients said they did not always receive continuity of care because they were unable to get an appointment with the same or preferred GP. Urgent appointments were available the same day.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs. However, access for patients with mobility difficulties was available but limited to support independent access. For example, the internal door was wide enough for patients who used wheelchairs but had a conventional handle with no assisted entry.
- There was a clear leadership structure and staff felt supported by the management.
- The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.
- Review the practice's system for sharing the outcome of significant events with staff to ensure timely action by all staff to improve safety.
- Review systems for checking the day-to-day cleanliness of patient facilities.
- Consider a review of staff training related to health and safety to ensure that all staff have the skills needed to deal with unexpected emergencies.
- Review practices in the reception area to ensure confidentiality when patients share private information and the recording of verbal complaints and concerns.
- Consider pro-actively identifying carers and establishing what support they need.
- Review access to the premises for patients with mobility difficulties to promote independent access or a safe means of assisted entry.

The areas where the provider must make improvements are:

- Ensure systems are put in place for the proper and safe management of medicines.
- Complete employment checks as required by legislation for all staff employed.

The areas where the provider should make improvements are:

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?

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

- There was a system in place for reporting and recording significant events. We saw that significant events were actioned immediately. However, there was a long period before the learning from these was shared with staff to ensure timely action was taken by all staff to improve safety in the practice.
- When things went wrong patients received reasonable support, relevant information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse. However, the practice could not confirm that all risks to patients were assessed. For example:
 - Safe recruitment checks were not completed for all staff.
 - Appropriate arrangements were not in place for the safe management of high risk medicines.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed that the overall achievement of 90% of the available points was slightly below average compared to the locality average of 92% and the England average of 95%.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- Arrangements were in place to gain patients' informed consent to their care and treatment.
- Patients were supported to access services to promote them living healthier lives.

Good



Are services caring?

The practice is rated as good for providing caring services.

Good



Summary of findings

- Data from the national GP patient survey results published in July 2016 showed patients rated the practice similar to others for several aspects of care.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect. Patients were concerned about the lack of confidentiality in the reception area and had made practice staff aware of this.
- The practice had a register of 51 carers, which represented 0.7% of the practice population. This was lower than the expected percentage of at least one percent.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example, the practice worked closely with secondary care professionals on initiatives to improve the care of patients with long-term conditions.
- Patients said they did not always receive continuity of care because they were unable to get an appointment with the same or preferred GP.
- The practice had good facilities and was well equipped to treat patients. However, access for patients with mobility difficulties was available but limited to support independent access. For example, the internal door was wide enough for patients' who used wheelchairs but had a conventional handle with no assisted entry.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. The method used to collect verbal complaints did not support patient confidentiality.

Good



Are services well-led?

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by the management. The practice had a number of policies and procedures to govern activity and held governance meetings.

Good



Summary of findings

- There was a governance framework which supported the delivery of the strategy and good quality care.
- 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.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a focus on continuous learning and improvement at all levels.

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 is rated as good for the care of older people.

Good



- The practice offered personalised care to meet the needs of the older patients in its population. Home visits and flexible appointments were available for older patients.
- Patients aged 75 years plus were offered annual health checks, allocated a named GP and were included on the practice hospital admission avoidance register.
- The practice provided a service to patients living in care homes. Staff had access to a direct telephone number at the practice for patients included on the practice hospital admission avoidance register.
- Older patients were offered urgent appointments for those with enhanced needs plus longer appointments which gave them more time to discuss health issues with a clinician.

People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

Good



- The GPs, nurses and healthcare assistants had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The GPs and nurses worked with relevant health care professionals to deliver a multidisciplinary package of care to patients with complex needs.
- The practice Quality and Outcomes Framework (QOF) results for the care of patients with long-term conditions were similar to or higher in most clinical areas compared to the local Clinical Commissioning Group (CCG) and England average. For example the percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was 88% compared with the CCG average of 87% and England average of 88%.
- Specific GP led clinics were held for patients whose diabetes was not well controlled.
- Patients with long-term conditions were signposted to community support networks, which helped to educate patients on their condition and encouraged self-care and socialisation.

Summary of findings

Families, children and young people

The practice is rated as good for the care of families, children and young people.

Good



- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Babies were given their first immunisations on the same day as mothers were offered their six week postnatal check.
- Immunisation rates were relatively high for all standard childhood immunisations.
- The practice's uptake for the cervical screening programme was 85%, which was higher than the local CCG average of 78% and England average of 82%.
- Protected daily appointments were available for children of all ages and children aged under the age of one were given priority and seen on the day. Appointments were available outside of school hours and urgent appointments were available for children.
- We saw positive examples of joint working with other professionals.

Working age people (including those recently retired and students)

The practice is rated as good for the care of working age people (including those recently retired and students).

Good



- The practice offered telephone consultations and online services, which included online prescription requests, booking appointment and access to patients own summarised medical records.
- Extended hours are offered by appointment only on Monday and Wednesday evenings from 6.30pm to 7.15pm and early morning appointments from 7.30am to 8am one morning per week.
- Patients had access to healthy lifestyles clinics carried out at the practice.
- Patients were signposted to a full range of health promotion and screening that reflected the needs of this age group.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

Good



- The practice had a register of 49 patients with a learning disability and worked with the local community learning

Summary of findings

disabilities nurses to ensure patients received annual health checks. Patients were offered a choice of appointment either at the practice or at their home. Information for this group of patients was also available in pictorial format.

- The practice was alerted to other patients whose circumstances may make them vulnerable or may present a risk to ensure that they were registered with the practice if appropriate. This included patients who were identified as being homeless and patients who misused substances that could harm their health and wellbeing.
- The practice had told vulnerable patients about how to access various support groups and voluntary organisations.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.

People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- The practice worked with multi-disciplinary teams in the case management of people who experienced poor mental health, including those with dementia.
- The practice held a register of patients who experienced poor mental health. Clinical data for the year 2014/15 showed that 87% of patients on the practice register who experienced poor mental health had a comprehensive agreed care plan in the preceding 12 months. This
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Counselling clinic sessions were held at the practice with an experienced mental health counsellor based in the community.
- The practice maintained a register of patients diagnosed with dementia. The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 90%, which was higher than the local CCG average of 82% and England average of 84%.

Good



Summary of findings

What people who use the service say

The national GP patient survey published in July 2016 showed that a total of 339 surveys (5% of patient list) were sent out and 123 (36%) responses, which is equivalent to 1.8% of the patient list, were returned. The results showed that the practice was performing similar to or lower than the local and national averages in several areas. For example:

- 74% of the patients who responded said they found it easy to get through to this surgery by phone compared to a Clinical Commissioning Group (CCG) average of 70% and a national average of 73%.
- 78% of the patients who responded said they were able to get an appointment to see or speak to someone the last time they tried (CCG average 80%, national average 85%).
- 75% of the patients who responded described the overall experience of their GP surgery as fairly good or very good (CCG average 83%, national average 85%).
- 62% of the patients who responded said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 73%, national average 78%).
- 84% of the patients who responded said they found the receptionists at this practice helpful (CCG average 84%, national average 87%).

As part of our inspection we also asked for Care Quality Commission (CQC) comment cards to be completed by patients prior to our inspection. We received 45 comment cards these were mainly positive about the standard of care. Patients said that the service was very good, fantastic and that staff were professional, attentive to patients' needs, helpful, polite and understanding. Six of the comments cards included concerns about access to appointments. Patients commented that consultations were at times not long enough, they felt rushed and no continuity as they never saw the same doctor. We spoke with four patients on the day of our inspection. The patients told us that they were satisfied with the care provided by the practice, felt that they received good treatment and were treated with respect.

The practice monitored the results of the friends and family test monthly. The results for July 2016 showed that 30 responses had been completed and of these, 11 (37%) patients were extremely likely to recommend the practice to friends and family if they needed similar care or treatment, 14 (47%) patients were likely to recommend the practice. The remaining results showed that one (3%) patient was unlikely to recommend the practice, one (3%) patient was extremely unlikely to recommend the practice and three (10%) patients stated that they did not know if they would recommend the practice.

Areas for improvement

Action the service **MUST** take to improve

- Ensure systems are put in place for the proper and safe management of medicines.
- Complete employment checks as required by legislation for all staff employed.

Action the service **SHOULD** take to improve

- Review the practice's system for sharing the outcome of significant events with staff to ensure timely action by all staff to improve safety.
- Review systems for checking the day-to-day cleanliness of patient facilities.

- Consider a review of staff training related to health and safety to ensure that all staff have the skills needed to deal with unexpected emergencies.
- Review practices in the reception area to ensure confidentiality when patients share private information and the recording of verbal complaints and concerns.
- Consider pro-actively identifying carers and establishing what support they need.
- Review access to the premises for patients with mobility difficulties to promote independent access or a safe means of assisted entry.

Woden Road Surgery

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 GP specialist advisor, a practice manager specialist advisor and an Expert by Experience.

Background to Woden Road Surgery

Woden Road Surgery is registered with the Care Quality Commission (CQC) as a partnership. The practice is close to main transport links for patients travelling by public transport. Parking is available for patients travelling by car. The practice is a two storey building with access for patients on the ground floor.

The practice team consists of four GP partners and two salaried GPs, three male and three females. The GPs are currently supported by two practice nurses and an assistant practitioner (healthcare assistant). Clinical staff are supported by a business manager, an office assistant, a medical secretary and six medical receptionists. In total there are 18 staff employed either full or part time hours to meet the needs of patients. The practice is a training practice for medical students, medical graduates and GP registrars. On the day of the inspection there were two foundation year two doctors working at the practice. The Foundation Programme is a two-year structured, supervised programme of workplace-based learning for medical school graduates. The programme prepares junior doctors for specialty training by providing them with the required medical knowledge and skills.

The practice is open between 8.30am and 7.15pm Monday and Wednesday, Tuesday 8.50am to 6pm, Thursday 8.50am to 12pm and Friday 8.50am to 5.30pm. The practice telephone lines are open at 8.30am. Appointments times with a GP are Monday to Friday 9am to 11am, Monday and Wednesday 3.30pm to 7.15pm, Tuesday 3pm to 6pm and Friday 3pm to 5.30pm. Appointments with a practice nurse are available Monday, Tuesday, Wednesday, Thursday and Friday 9am to 11am, Monday, Tuesday and Wednesday 3.30pm to 6pm and Friday 3pm to 5.30pm. Extended hours are offered by appointment only on Monday and Wednesday evenings from 6.30pm to 7.15pm and Tuesday mornings from 7.30am to 8am. This practice does not provide an out-of-hours service to its patients but has alternative arrangements for patients to be seen when the practice is closed. Patients are directed to Wolverhampton Doctors on Call Limited when the practice is closed at lunchtime and on Thursday afternoon. At all other times when the practice is closed, the patients are directed to the out of hours service Vocare via the NHS 111 service.

The practice has a General Medical Services contract with NHS England to provide medical services to approximately 6,800 patients. It provides Directed Enhanced Services, such as childhood vaccinations and immunisations and the care of patients with a learning disability. The practice is located in one of the most deprived areas of Wolverhampton. People living in more deprived areas tend to have a greater need for health services. There is a higher practice value for income deprivation affecting children and older people in comparison to the practice average across England. The level of income deprivation affecting children of 38% is higher than the national average of 20%. The level of income deprivation affecting older people is higher than the national average (35% compared to 16%).

Detailed findings

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 15 August 2016.

During our visit we:

- Spoke with a range of staff including the GPs, business manager, reception staff and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members.

- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.'

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups are:

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the Care Quality Commission (CQC) at that time.

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events. Staff told us they would inform the business manager or GP of any incidents and there was a recording form available. 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). We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, relevant information, a written apology and were told about any actions to improve processes to prevent the same thing happening again. The practice carried out a thorough analysis of the significant events. The business manager received medicine and safety alerts and evidence was available to show that these were appropriately actioned. The business manager disseminated alerts to relevant staff. Documents available showed that alerts were seen, read and acted on by appropriate staff and these were signed to confirm this.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. The practice had recorded eight significant events both clinical and operational that had occurred between August 2015 and January 2016. One of the events showed that a local pharmacy requested prescriptions for patients that were not registered with the practice. Records showed that the incident was discussed with the pharmacy concerned. We saw that although significant events were actioned immediately, there was a long period, for example, eight months on one occasion, before the outcome and learning from these were shared with staff to ensure all staff were aware of the changes made to improve safety at the practice.

Overview of safety systems and processes

The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined

who to contact for further guidance if staff had concerns about a patient's welfare. One of the GP partners was the lead member of staff for safeguarding. The GP attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs and practice nurses were trained to child safeguarding level three. The practice routinely reviewed and monitored children who did not attend appointments and also maintained a list of children who were included on the child protection register. Staff told us that patients, children and vulnerable adults who did not attend hospital appointments were followed up. Information available showed that only six occasions related to non-attendance at hospital appointments had been recorded. Staff felt that this low number could be due to incorrect coding and indicated that a review would be carried out. Records confirmed that the six patients had been followed up. Suspected safeguarding concerns were shared with health visitors and midwives linked to the practice and other relevant professionals.

- A notice in the waiting room advised patients that chaperones were available if required. All staff had completed chaperone training and had received a Disclosure and Barring Service (DBS) check. (DBS
- Treatment and consulting rooms in use had the necessary hand washing facilities and personal protective equipment which included gloves and aprons. Clinical staff had received occupational health checks for example, hepatitis B status and appropriate action taken to protect staff from the risk of harm when meeting patients' health needs. Appropriate clinical waste disposal contracts were in place. The practice nurse was the clinical lead for infection control. There was an infection control policy in place and some staff had received up to date training. Annual infection control audits were undertaken by an external organisation and we saw that the outcome for these had been consistently high over the last three years. The practice had taken appropriate action to address any improvements identified by the audits. However, we observed that an appropriate standard of cleanliness and hygiene was not maintained throughout the premises. It was noted that the toilet facilities for patients with a disability was dirty and this included the

Are services safe?

toilet and the light pull cord and hand cleaning gel was not available in all toilets. There were cleaning schedules in place and cleaning records were maintained, however records were not available to confirm that regular checks were made to ensure standards were maintained.

- The management of most medicines at the practice kept patients safe (including obtaining, recording, handling, storing, security and disposal). This included the safe management of emergency medicines and vaccines. The practice carried out regular medicines audits, with the support of the local pharmacy advisor, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.

The practice used a risk assessment tool to monitor its repeat prescribing procedures. The risk assessment identified that effective systems were not in place to manage all uncollected prescriptions. We were told that uncollected prescriptions for controlled medicines were referred to the prescribing GP but others were shredded without making the prescribing GP aware. There was no system in place to monitor or confirm this practice. We also found that the practice did not have effective systems in place for the prescribing and monitoring of high risk medicines. There were shared care agreements in place with a local hospital for some patients, prescribed high risk medicines that needed to be monitored. We saw that the results of blood tests carried out at the hospital were not routinely obtained before giving patients' a repeat prescription. These issues were discussed with the GPs who planned to review their current practice which included a review of all patients and developing appropriate policies and procedures to address this.

Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. The health care assistant was trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber. At the time of the inspection we were unable to evidence that current PSDs were available. Following the inspection the practice manager provided evidence to demonstrate that current PSDs had been completed. The practice had systems for ensuring that medicines were stored in line

with manufacturers guidance and legislative requirements. This included daily checks to ensure medicines were kept within a temperature range that ensured they were effective for use.

We reviewed four personnel files and found that there was evidence that qualification and had been completed for the practice nurses and GPs. The practice had also ensured that appropriate checks had been completed. We noted that references had not been obtained for a newly appointed receptionist. The practice used GP locums to support the clinicians and meet the needs of patients at the practice. The practice had a checklist to support the recruitment of locum GPs. However, records available did not demonstrate that the practice had obtained sufficient and appropriate information such as DBS checks, immunity status and evidence of ongoing training such as safeguarding of children and vulnerable adults to confirm that the locum staff were suitable to work with patients at the practice.

Monitoring risks to patients

Risks to patients were assessed and well managed. There was a health and safety policy available with a poster in the reception area which identified the health and safety representative. Records were available to demonstrate that the safety of the premises was regularly monitored and maintained. For example, annual services had been completed on the gas and electrical services. Although staff had not received formal fire awareness training, the practice had carried out regular fire drills and maintained records on staff and patient response to the drill. The practice did not have a fire alarm but used a tannoy system to alert staff and patients to an emergency. Records identified good practice and areas where improvement were needed. Staff confirmed that they attended regular fire drills. The practice provided evidence after the inspection to confirm that fire awareness training had been booked for all staff to attend. Records showed that fire risk assessments had been completed but these did not include checking the emergency lights and smoke alarms to ensure that they would work in the event of a fire.

All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. A health and safety risk assessment had been completed and recommendations made had been actioned. The practice had other risk assessments in place to monitor the safety of

Are services safe?

the premises such as the security of the premises, general risk assessments of the environment, control of substances hazardous to health, infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff and staff with appropriate skills were on duty. The practice used locum GPs to help meet the needs of patients at times of GP absence such as annual leave.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents, which included:

- An instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and copies of the plan were kept off site.
- All staff received annual basic life support training. The practice had a defibrillator available on the premises and adult and children's oxygen masks. We saw that the practice had two oxygen cylinders however one was half full but had expired in August 2015 and the other was empty. Following the inspection the business manager sent us evidence to confirm that the oxygen cylinders had been replaced. A first aid kit and accident book were available.
- Emergency medicines were available, easily accessible to staff in a secure area of the practice and all staff knew of their location. The GPs carried some emergency medicines; these were in date and were regularly checked by the GPs. All the medicines we checked were in date and stored securely.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed patients' needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. The GP partners could clearly outline the rationale for their approach to treatment. The practice used electronic care plan templates based on NICE guidance. Examples of these were seen and included templates for asthma. To ensure clinical staff were familiar with current best practice guidance updates were provided through continuous teaching and training sessions provided and included presentations by GP registrars and medical students. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF and reviewed their performance against the national screening programmes to monitor outcomes for patients. The practice achieved 90% of the total number points available for 2014-2015. This was slightly lower than the local Clinical Commissioning Group (CCG) average of 92% and the England average of 95%. The practice clinical exception rate of 9.7% was higher than the CCG average of 7.5% and the England average of 9.2%. Clinical exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects. Further practice QOF data from 2014-2015 showed:

- The practice performance in four of the five diabetes related indicators was comparable or higher than the local CCG and England averages. For example, The percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was 88% compared

with the CCG average of 87% and England average of 88%. The practice exception reporting rate of 6.5% showed that it was higher than the local average of 4.8% and lower than the England average of 7.6%.

- Performance for the percentage of patients with who had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale (the degree of breathlessness related to five specific activities) in the preceding 12 months was 100%. This was higher than the local CCG average of 91% and England average of 90%. COPD is the a collection of lung diseases. The practice exception reporting rate of 11% showed that it was higher than the local average of 6.8% and similar to the England average of 11.1%.
- Performance for mental health related indicators was higher or similar to the local CCG and England averages. For example, the percentage of patients with mental health disorders who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 87% compared to the local CCG average of 88% and England average of 89%. The practice clinical exception rate of 6.9% for this clinical area was lower than the local CCG average of 8.7% and the England average of 12.6%.
- The percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was higher than the local CCG average and England averages (90% compared with the CCG average of 82% and England average of 84%). The practice clinical exception rate of 7.3% for this clinical area was lower than the local CCG average of 7.7% and the England average of 8.3%.

The practice had performed similar overall when compared to the local CCG and England averages. However, there were two clinical areas that showed a significant large variation. Both these areas were related to the management of patients with high blood pressure. One of these showed that the percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 mmHg or less was 56%. This was lower than the local CCG average of 75% and England average of 78%. The practice had introduced a number of changes and was involved in local initiatives to support improvements in the review of patients with chronic health conditions. For example, Specific GP led clinics were held for patients whose

Are services effective?

(for example, treatment is effective)

diabetes was not well controlled. The practice also worked closely with hospital specialists to support the care of these patients. We saw that the CCG benchmarked the practice against other practices in the locality. The GPs attended peer review meetings with other local GP practices where clinical issues, treatments and performance were discussed.

Clinical audits were carried out to facilitate quality improvement and the practice encouraged all staff to carry out audits this included the nurses. We saw records for three clinical audits carried out over the last two years. Two of the audits were two cycle audits. One of the audits looked at whether the practice prescribed inhalers for patients with COPD in line with clinical guidance. The first audit randomly selected 50 patients and of these four (8%) of the patients reviewed were not using the appropriate inhalers. These patients were asked to attend a medication review. A further search was carried out to identify all patients not prescribed the appropriate inhalers. These patients were also invited to attend the practice for a medication review. The findings of the audit, the guidance and recommendations were shared with the GPs and GP registrars. A second audit carried out six months later randomly identified 50 patients with COPD and the results showed that all the patients had been prescribed the recommended combination of inhalers in line with clinical guidance.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. The practice had an induction programme for all newly appointed staff. A copy of the induction programme showed the topics covered included health and safety, equality and diversity and first aid. Records we looked at showed that training completed by some staff included basic life support, safeguarding and infection control, infection prevention, chaperoning and information governance. We found that there were gaps in the number of staff that had attended health and safety related training. For example, records showed that three staff had received infection prevention and control training, four staff had attended fire safety awareness and one member of staff had received information governance training. We were reassured that the business manager would address this. We received evidence following the inspection to confirm that an update in fire safety awareness had been booked for all staff.

The learning needs of staff were identified through a system of appraisals, meetings and reviews of their individual development needs. All staff had had an appraisal within the last 12 months. The GPs and practice nurses had all completed clinical specific training updates and competency assessments to support annual appraisals and revalidation. The practice nurses had completed accredited courses in the management of patients with COPD and diabetes and practice skills such as taking blood. The practice paid for the annual professional registration fee of its nurses and one of the nurses had recently completed their revalidation, which had been assessed by one of the partners. The practice was an approved training practice and an advanced training for GP registrars, foundation year two doctors and medical students.

Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources, discussions at practice and external meetings.

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. This included care and risk assessments, care plans, medical records and investigation and test results. The practice shared relevant information with other services in a timely way, for example when referring patients to other services. Referrals to other services included physiotherapy, hearing services and community mental health services for children and adults. The practice provided a service to older people in care homes. We received a statement from one of the managers at one of the care homes and a spoke with another on the telephone. Both managers told us that they were happy with the service they received from the practice.

Staff told us that it was difficult to arrange formal multi-disciplinary team meetings. To overcome this the practice maintained informal liaison with the local hospice, Macmillan team, community matron and district nurses. The practice worked with other health and social care professionals such as hospital consultants and members of the learning disability team to understand and meet the

Are services effective?

(for example, treatment is effective)

range and complexity of patients' needs. This ensured that the practice could appropriately assess and plan the ongoing care and treatment of its patients when patients moved between services, including when they were referred, or after they were discharged from hospital.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Staff from the community healthy lifestyles team carried out clinics at the practice. The team provided patients with information on healthy living related to diet, lifestyle and exercise.

Patients had access to appropriate health assessments and checks. For example, patients with a learning disability were offered a comprehensive health review. Joint clinics were provided by the designated lead GP, assistant practitioner and a nurse from the learning disabilities community team. Health checks were also carried out in

patient homes where appropriate to help decrease patient anxiety. The practice offered health checks to new patients and patients aged 40 to 74 years. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

The uptake for cervical screening for women between the ages of 25 and 64 years for the 2014/15 QOF year was 85% which was higher than the local CCG average of 78% and the England average of 82%. The practice was proactive in following these patients up by telephone and sent reminder letters. Public Health England national data showed that the number of female patients screened for breast cancer was comparable to the local CCG and England average. The data for breast and bowel cancer screening showed that the number of patients screened was also comparable to the England averages. Due to concerns about patients delaying attendance at appointments to support early diagnosis the practice was proactive in educating patients about being cancer aware and seeking early advice.

Travel vaccinations and foreign travel advice was offered to patients. Childhood immunisations and influenza vaccinations were available in line with current national guidance. Data collected by NHS England for 2014/15 showed that the performance for childhood immunisations was comparable to the local CCG averages for example immunisation rates for:

- under two years of age ranged from 70% to 91%, (CCG average 74% to 96%),
- children aged two to five 75% to 96%, (CCG average 84% to 96%)
- children aged five year olds from 80% to 94%, (CCG average 77% to 95%)

The practice worked with the health visitors and local centre for children to follow up children who did not attend for their immunisation.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed that members of staff were courteous and helpful to patients and patients were treated with dignity and respect. Consultations and treatments were carried out in the privacy of a consulting room to maintain patients' privacy and dignity during examinations, investigations and treatments. Consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard. We found that it was possible to hear conversations at the reception desk. Full conversations between patients and receptionists could be overheard asking patients why they needed to see the doctor. Two of the patients we spoke with reported their concerns about the lack of privacy but said that if they asked for privacy, they would be taken into the corridor or into a room where they could speak in private. The three members of the patient participation group (PPG) we spoke with told us that the lack of confidentiality in the reception area had been discussed at meetings and they were assured that the practice was doing all it could. However, there were no notices for patients to make them aware that they could ask to speak in private. Patients were encouraged to queue away from the reception desk and not stand directly behind a patient speaking to reception staff at the desk.

We received 45 Care Quality Commission (CQC) comment cards. Comment cards highlighted that patients were generally positive about the service they received. Patients commented that staff treated them with respect and responded compassionately when they needed help. Comments cards highlighted patient concerns about feeling rushed at appointments and lack of continuity as unable to see the same GP. The results from the national GP survey published in July 2016. The results showed that 43% of patients with a preferred GP usually get to see or speak to that GP which was lower than the local CCG and national averages of 59%. However, 92% of patients said they had confidence and trust in the last GP they saw compared to the local CCG average of 93% and the national average of 95%.

Further results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice patient satisfaction scores were lower than or similar to the local and national averages for its with GPs and nurses. For example:

- 81% of patients said the GP was good at listening to them compared to the local clinical commissioning group (CCG) average of 85% and the national average of 89%.
- 82% of patients said the GP gave them enough time compared to the local CCG average of 83% and the national average of 87%.
- 80% of patients said the last GP they spoke to was good at treating them with care and concern compared to the local CCG average of 81% and the national average of 85%.
- 84% of patients said the nurse was good at listening to them compared to the local CCG and national averages of 91%.
- 83% of patients said the nurse gave them enough time compared to the CCG average of 91% and the national average of 92%.
- 98% of patients said they had confidence and trust in the last nurse they saw compared to the local CCG average of 96% and the national average of 97%.
- 79% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the local CCG average of 88% national average of 91%.

The patient satisfaction with reception staff was similar to the local CCG and national average. Data showed that:

84% of the patients who responded said they found the receptionists at the practice helpful (CCG average 85%, national average 87%).

Care planning and involvement in decisions about care and treatment

Results from the national GP patient survey showed patients responded less positively to questions about their involvement in planning and making decisions about their care and treatment. Results were below the local and national averages. For example:

- 78% of the patients who responded said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83% and national average of 86%.

Are services caring?

- 76% of the patients who responded said the last GP they saw was good at involving them in decisions about their care (CCG average 76%, national average 82%).
- 83% of the patients who responded said the last nurse they saw or spoke to was at explaining tests and treatments (CCG average 89%, national average 90%)
- 76% of the patients who responded said the last nurse they saw was good at involving them in decisions about their care (CCG average 83%, national average 85%).

Patients told us they felt involved in decision making about the care and treatment they received. However some patients told us that they did not always feel listened to by staff and felt rushed during consultations. Patient feedback from the comment cards we received although generally positive were aligned with these views. The practice was aware of the areas in which they were performing lower than the local and England averages and followed up these results when carrying out patient surveys at the practice.

The practice provided facilities to help patients be involved in decisions about their care. The practice had an increasing number of patients whose first language was not English. Staff told us that translation services were available for patients. We saw notices in the reception areas informing patients this service was available.

Information leaflets were available in easy read format. Patients were directed to the local refuge and migrant centre for support. Some GPs spoke more than one language.

Patient and carer support to cope emotionally with care and treatment

The practice had 51 patients over the age of 18 years on its practice carers register. This represented 0.7% of the practice population. Notices, leaflets and booklets for carers were displayed in the reception area. The information available informed patients about the support and services provided both at the practice and in the local community. The practice offered carers health checks and the flu vaccination.

Patients felt positive about the care and support they received to cope with their bereavement. Staff told us that if families had suffered bereavement, they were contacted by their usual GP and provided with support when appropriate. Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of bereavement and counselling support groups and organisations. Information about support groups was also available on the practice website.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local Clinical Commissioning Group (CCG) to plan services and to improve outcomes for patients in the area. Services were planned and delivered to take into account the needs of different patient groups, flexibility, choice and continuity of care. For example:

- The practice maintained a register of 123 patients who experienced poor mental health. Patients were offered continuity of care and the practice ensured that patients had access to appointments with a counsellor and other community based professionals.
- The practice had a register of 49 patients with a learning disability and worked with the local community learning disabilities nurses to ensure patients received annual health checks and longer appointments. This group of patients were offered a choice of appointment either at the practice or at their home to support their needs. Information about health care and appointments was available in pictorial format.
- The practice had identified 155 (2.3%) patients on its hospital admission avoidance register and had completed care plans to appropriately monitor and manage their care.
- Patients with long-term conditions for example, diabetes, Chronic Obstructive Pulmonary Disease (COPD, the name for a collection of lung diseases) and dementia were signposted to community support networks. The networks helped to educate patients on their condition and encouraged self-care and socialisation.
- Patients were able to receive travel vaccinations available on the NHS and were referred to other clinics for vaccines available privately.
- The practice offered extended clinic appointments three days per week for working patients who could not attend during the normal opening hours. The practice also offered online access to making appointments and ordering repeat prescriptions.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice offered patients the choice of an appointment with a male or female GP to meet their preferences.

- Access for patients with mobility difficulties was available but limited. There was a raised slope at the front entrance but its design did not ensure that patients who used a wheelchair could access the premises easily and without assistance. The external doors were not automatic but remained open during practice hours. We observed that the internal door was wide enough for patients' who used wheelchairs but only had a conventional handle and no assisted entry.
- A hearing loop was available, for patients with hearing impairments and staff were aware of how to use the system.
- There were longer appointments available for older patients and patients with long-term conditions.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.

Access to the service

The practice was open between 8.30am and 7.15pm Monday and Wednesday, Tuesday 8.50am to 6pm, Thursday 8.50am to 12pm and Friday 8.50am to 5.30pm. The practice telephone lines were open at 8.30am. Appointments times with a GP were Monday to Friday 9am to 11am, Monday and Wednesday 3.30pm to 7.15pm, Tuesday 3pm to 6pm and Friday 3pm to 5.30pm. Appointments with a practice nurse were available Monday, Tuesday, Wednesday, Thursday and Friday 9am to 11am, Monday, Tuesday and Wednesday 3.30pm to 6pm and Friday 3pm to 5.30pm. Extended hours were offered by appointment only on Monday and Wednesday evenings from 6.30pm to 7.15pm and Tuesday mornings from 7.30am to 8am. The practice did not provide an out-of-hours service to its patients but had alternative arrangements for patients to be seen when the practice was closed. Patients were directed to Wolverhampton Doctors on Call Limited when the practice was closed at lunchtime and on Thursday afternoon. At all other times when the practice was closed patients were directed to the out of hours service Vocare via the NHS 111 service.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was similar to the local and national averages. For example:

- 73% of patients who responded were satisfied with the practice's opening hours compared to the local average of 77% and England average of 76%.

Are services responsive to people's needs?

(for example, to feedback?)

- 74% of patients who responded said they could get through easily to the surgery by phone (local average 70%, England average 73%).

Patients commented that there were delays in getting appointments. Access to the practice and the appointment system was continuously reviewed and discussed. The practice responded to the results of patients feedback in surveys and shared and discussed how to improve patients' experience of access to the practice at practice meetings and with the patient participation group (PPG). Notices were displayed in the reception area to make patients aware of the action the practice had taken for example, the number of online appointments had been increased in response to patients request for more appointments.

The practice had a system in place to assess whether a home visit was clinically necessary and the urgency of the need for medical attention. Information on the practice website told patients to contact the practice before 10.30am to request a home visit. The GP on duty for the day at the practice allocated the home visits to the GP registrars. The duty GP was available for advice if needed. The practice kept a computerised record of home visits requested and carried out. Non-clinical staff referred any calls which caused concern or they were unsure of to the duty GP for advice. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits. The GP made a decision on the urgency of the patients' need for care and treatment and the most suitable place for this to be received.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The system in place was not fully in line with recognised guidance and contractual obligations for GPs in England. The practice encouraged patients to enter any concerns, complaints or suggestions they had in a book which was kept in the reception area. We saw that the book was kept open and complaints had been recorded. Patients were asked to include their name and details if making a complaint. Responses to the complaints had been entered in the complaints book, most were responded to and signed off by the business manager but some were not signed by the person who had provided the response. Patients we spoke with expressed concerns that the complaint book was kept open where it could easily read by other patients. The business manager indicated that the system would be reviewed.

Patients were advised to ask for a copy of the complaints procedure if they wished to make a complaint. We saw that information was available to help patients understand the complaints system including leaflets available in the reception area. Patients we spoke with were aware of the process to follow if they wished to make a complaint. The business manager was responsible for managing complaints at the practice. The practice had received six complaints in the last 12 months. Records we examined showed that both verbal and written complaints had been investigated and responded to in line with the practice complaints policy. The complaints were discussed at practice meetings and with appropriate staff. Records identified that lessons were learnt from individual concerns and complaints and action was taken to improve the quality of care.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice mission and values statement was identified in its statement of purpose. The vision for the practice was shared and discussed at the patient participation group (PPG) meetings. The practice vision aimed to provide the best possible patient care to its varied patient population within a highly deprived area of Wolverhampton. Staff and patients felt that they were informed and encouraged to be involved in the future plans for the practice. The practice was aware of the plans in place to improve the local area which would impact on the practice. The practice had considered a number of varied strategies and business ideas for example merging with other health organisations to support its long-term development. Annual team away days were held to discuss the plans for the future development of the practice.

Governance arrangements

Governance within the practice was mixed. We saw examples of risks that had been well managed:

- The practice held regular meetings at which governance issues were discussed. There was a structured agenda and an action plan.
- There was a clear staffing structure and all staff were clear about their own roles and responsibilities. All staff were supported to address their professional development needs.
- The GP partners and nurses had designated clinical lead roles. Both clinical and non-clinical staff also held additional responsibilities which supported the day to day operation of the practice.
- Arrangements for identifying, recording and managing risks and implementing mitigating actions were in place but did not cover all areas to ensure that patients and staff were protected from the risk of harm at all times. These included for example, the arrangements for the safe recruitment of locum staff and clear systems for the management of high risk medicines.
- Practice specific policies and procedures were implemented and were available to all staff.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.

Leadership and culture

There was a clear leadership structure in place and staff felt supported by the management. We saw agendas and minutes of meetings which confirmed that practice meetings were held both by teams of staff and practice wide. Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Staff we spoke with were positive about working at the practice. Staff said they felt respected, valued and supported. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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, relevant information and a verbal and written apology. The practice kept written records of verbal interactions as well as written correspondence.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service. The practice had varied methods in place to gather feedback from patients who used the service which included comments, suggestions and complaints received. The practice had an established PPG group who were kept aware of the practice plans, which included improvement of the premises and involvement in planning the winter flu clinics. The PPG met regularly and submitted proposals for improvements to the practice management team. The practice had also gathered feedback from patients through patient surveys and had addressed concerns raised by patients. For example, the practice was looking how they could improve confidentiality in the reception area.

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff told us

Are services well-led?

Good 

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

they would not hesitate to give feedback and discuss any concerns or issues with colleagues and the management team. The practice staff worked effectively as a team and their feedback was valued. Staff were actively encouraged by the management team to improve how the practice was run; some staff had accepted additional roles to support this. Examples of changes made at the practice as a result of suggestions made by staff included the introduction of colour coded letters to invite patients with diabetes to attend an appointment. The colour of the paper used for the letters identified whether the patient had to book an appointment with a nurse or a GP.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was part of local pilot schemes to improve outcomes for patients in the area. The practice was involved in a number of local pilot initiatives which supported improvement in patient care across Wolverhampton. The

GPs could demonstrate involvement in clinical meetings with their peers to enable them to discuss clinical issues they had come across, new guidance and improvements for patients. The practice had completed reviews of significant events and other incidents. We saw records to confirm this. The practice also reviewed incidents that had been handled well by staff and shared these as examples of good practice.

The practice was an approved training practice for GP registrars, foundation year two doctors and medical students. The practice also provided advanced training for GP registrars who had found it difficult to complete the required training in the three-year training period. Three of the GP partners were GP trainers and all the partners and salaried GPs carried out tutorials with the trainees. Tutorials were arranged three days per week and separate training sessions were planned for the medical students based on their educational needs.

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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">• Appropriate arrangements were not in place for the proper and safe management of:<ul style="list-style-type: none">▪ All uncollected prescriptions.▪ High risk medicines.• The provider had not ensured that they consistently made all appropriate checks on persons employed for the purposes of carrying on a regulated activity before they were employed.