Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

General Practice Inspection (Announced)

Meddygfa Albany Surgery: Cardiff and Vale University Health Board

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1. Introduction

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of all health care in Wales.

HIW's primary focus is on:

- Making a contribution to improving the safety and quality of healthcare services in Wales
- Improving citizens' experience of healthcare in Wales whether as a patient, service user, carer, relative or employee
- Strengthening the voice of patients and the public in the way health services are reviewed
- Ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.

HIW completed an inspection at Meddygfa Albany Surgery, at 219-221 City Road, Cardiff CF24 3JD on 23 February 2017. Our team, for the inspection comprised of an HIW inspection manager (inspection lead), GP and practice manager peer reviewers and representatives from Cardiff and Vale of Glamorgan Community Health Council.

HIW explored how Meddygfa Albany Surgery met the standards of care set out in the Health and Care Standards (April 2015). Inspections of General Medical Practice (GP) inspections are announced and we consider and review the following areas:

- Quality of the patient experience - We speak to patients (adults and children), their relatives, representatives and/or advocates to ensure that the patients' perspective is at the centre of our approach to how we inspect
- Delivery of safe and effective care - We consider the extent to which, services provide high quality, safe and reliable care centred on the person
- Quality of management and leadership - We consider how services are managed and led and whether the culture is conducive to providing safe and effective care. We also consider how services review and monitor their own performance against relevant standards and guidance.

More details about our methodology can be found in section 6 of this report.

2. Context

Meddygfa Albany surgery currently provides services to approximately 7100 patients in the Cardiff city area. The practice forms part of GP services provided within the area served by Cardiff and Vale University Health Board.

The practice employs a staff team which includes two full-time GP partners (shortly to become three), three salaried GPs, a Practice Manager, one full-time and two part-time practice nurses, and a team of administrative/reception staff.

Health visitors, community based nurses, phlebotomists (who assist with taking patients' blood tests) midwives, Stop Smoking Wales counsellors and a Community Addiction Unit Advisor (who are employed by the health board) also work with the staff team at the practice.

The surgery provides a range of primary care services which includes:

- Management of long term health conditions
- Counselling
- Cervical smear screening
- Contraceptive services/sexual health advice
- Vaccinations and immunisations (adults and children)
- Minor surgery
- Maternity services
- Travel vaccinations and advice
- Substance misuse clinics
- Smoking cessation clinics

For ease of reading, Meddygfa Albany Surgery will be referred to as 'the practice' throughout this report.

3. Summary

HIW explored how the practice met standards of care as set out in the Health and Care Standards (April 2015).

We were able to confirm that the practice team placed an emphasis on the provision of safe and effective care to patients.

We also found that the leadership provided by the GPs and the Practice Manager and Deputy respectively, resulted in a positive working culture. We also found that there were robust and well established processes and systems in place in support of the efficient running of the service.

This is what we found the practice did well:

- We reviewed the content of four to five sets of electronic patient records for each clinical member of staff and found that they had provided patients with sufficient information about their health condition, investigations needed and options for managing their health and wellbeing
- Staff were clear about their roles and day to day responsibilities and they also told us that they felt supported by all members of the practice team
- We saw that all areas of the practice occupied by patients were very well presented and maintained, pleasantly decorated, clean and uncluttered, which reduced the risk of falls within the premises

This is what we recommend the practice could improve:

- The practice is required to ensure that non clinical staff are made aware of what is expected of them when they are requested to act as a chaperone
- The practice is required to ensure that it manages patients' concerns/complaints in accordance with Putting Things Right arrangements
- The practice is required to ensure that there is no delay in recording the outcome of house call consultations within patients' electronic records

4. Findings

Quality of the patient experience

Two members of the local Cardiff and Vale of Glamorgan Community Health Council (CHC) were present at the practice on the day of our inspection. Their role was to seek patients' views with regard to services provided by Meddygfa Albany Surgery through the distribution of questionnaires and via face to face conversations with people and/or their carers.

The CHC had provided the practice with 200 questionnaires prior to the inspection, with a request that patients be provided with the opportunity to comment on the practice's services. Of that number, 88 were completed in addition to further responses obtained on the day of our visit.

The CHC have produced a report which provides an analysis of the information gathered. That report can be found at Appendix B.

We identified the need for some improvement regarding chaperone arrangements, and those which related to the acknowledgement and management of patients' concerns/complaints.

Staying healthy

Standard 1.1 Health promotion, protection and improvement *People are empowered and supported to take responsibility for their own health and wellbeing and carers of individuals who are unable to manage their own health and wellbeing are supported. Health services work in partnership with others to protect and improve the health and wellbeing of people and reduce health inequalities.*

We reviewed the content of four to five electronic patient records for each member of the clinical team and found that they had provided patients with sufficient information about their health condition, investigations needed and options for managing their health and wellbeing.

We saw a variety of health promotion/lifestyle information on display in the patient waiting area, for people to take away with them for future reference. The practice leaflet was readily available to people, together with information about support services and organisations. All such information was found to be relevant and current.

The practice's website contained useful patient information as did noticeboards in the patient waiting area.

We found that the practice did not have a nominated 'Carer's Champion' at the time of this inspection; the member of staff who had been nominated for that role having left the practice in recent months.

Carers' Champions have a valuable contribution to make, in terms of assisting patients' carers, offering them the opportunity to discuss the challenges they face, and providing them with useful information about various agencies and organisations that may be able to support them with their day to day responsibilities. We therefore discussed this matter with the practice team who expressed a willingness to nominate another member of staff to fulfil the role.

Staff described that the practice was in the process of arranging for a Consultant from the local hospital to provide prompt advice regarding management of patients with complex Diabetes. We were also informed that smoking cessation clinics being held every week were proving to be very successful. This approach to patient care was commended by the inspection team.

We found that the practice partners and management staff adopted a positive approach to the work and development of the GP cluster[1] in the area, as a means of improving services and support to patients in the future. Information exchange had included:

- Discussions about how to improve electronic coding of patient falls and subsequent referrals for assessment
- Information sharing with regard to improving standards of care for patients with heart failure

In addition, the cluster had been successful in securing the services of a community pharmacist to assist with medication reviews and a frailty nurse to support patients in their own homes.

[1] A GP practice 'Cluster' is a grouping of GPs and Practices locally determined by an individual NHS Wales Local Health Board. GPs in the Clusters play a key role in supporting the ongoing work of a Locality (health) Network for the benefit of patients.

However, the practice was open and honest about the challenges faced in working with the GP cluster. This was largely due to the differences in the needs of the practice populations involved.

All relevant staff had completed self assessment questionnaires in terms of the regular use of display screen equipment and adjustments made to their work stations accordingly. This was in-keeping with health and safety legislation.

Dignified care

Standard 4.1 Dignified care

People's experience of healthcare is one where everyone is treated with dignity, respect, compassion and kindness and which recognises and addresses individual physical, psychological, social, cultural, language and spiritual needs.

We were able to confirm that the practice had well established systems in place to ensure patients' confidentiality. For example, staff were required to sign a confidentiality agreement following checks of their understanding of their roles and responsibilities in this regard. The staff handbook also made reference to the need to maintain patient confidentiality.

Observation of the way which staff (at the open reception area) spoke with patients on their arrival, confirmed that efforts were made to speak in soft tones to prevent other people from overhearing the conversation taking place. We also found that telephone conversations with patients (incoming and out-going calls), were generally made within the confines of the office at the rear of the reception area to ensure that patients' information was discussed in a confidential manner at all times.

We discussed the use of chaperones (male and female) in relation to patient examinations and found that the practice tried to ensure that clinical staff were used in this role wherever possible. In addition, we were able to confirm that patients' records clearly indicated times when a chaperone was required. We also found that, on the rare occasions that a member of the clinical team was not available for chaperone duties, patients were offered an alternative appointment. However, we found that non clinical staff had not received training regarding chaperone duties. Whilst they were only required to take on that role on an occasional basis, the practice was advised of the need to address this matter. This was to ensure that staff understand what is expected of them.

Improvement needed

The practice is required to inform HIW of the action taken/to be taken to ensure that non clinical staff are made aware of what is expected of them at such times when they are requested to act as a chaperone.

We were shown the room (adjacent to the reception), which we were informed would be used should patients wish to speak to reception/practice staff privately. We were also informed that patients who wished to register with the practice had the opportunity to use the room so that they could complete the relevant paperwork in private and with the support of a member of the practice's administrative staff, if needed.

We saw that doors to consulting/treatment rooms were closed at times when practice staff were consulting with patients. We were also made aware that consulting rooms were soundproofed. This meant that appropriate steps were being taken to maintain patients' privacy and dignity.

We found that electronic records demonstrated that patients' consent had been obtained prior to undertaking clinical procedures.

Standard 4.2 Patient information

People must receive full information about their care which is accessible, understandable and in a language and manner sensitive to their needs to enable and support them make an informed decision about the care as an equal partner.

Standard 3.2 Communicating effectively

In communicating with people health services proactively meet individual language and communication needs.

We found that internal communication systems at the practice appeared to work well. For example, we considered the process in place for patients and/or parents of children to receive results from blood tests and other investigations and were able to determine that each GP received the results of any investigations they requested, contacting patients as needed. We were also told that when a GP was on holiday, test results were reviewed by other GPs. In addition, we were informed that patients were advised to contact the practice to obtain their results.

Whilst there was no communications policy in place, there were established systems in place to record and share internal communication, to ensure that messages about patient care were not missed or delayed in reaching the relevant member of staff. The practice may, however, wish to consider

developing a communication policy which would assist in streamlining the ways in which information is shared and also result in a clearer information audit trail.

We were able to confirm that staff would use a confidential translation service to assist patients whose first language was not English to discuss their health related problems with doctors and nurses, if required. We were also able to confirm that relevant patient information was available in different languages.

Conversations with one of the practice nurses revealed how they used a website to translate information about immunisations for patients who did not speak English as their first language. The practice was commended for this approach to supporting patients.

A hearing loop system was available to patients with hearing difficulties. This was located at reception with signs about such assistance being displayed on a notice board away from the reception. The equipment was tested during inspection and found to be working. There was a tannoy system in place to call patients to consultation rooms. However, some clinical staff chose to personally escort patients from the waiting area.

There were no bilingual (Welsh) patient practice leaflets on display at the time of our inspection and staff told us that they had never been requested for information in any language other than English. However, signs at the premises were displayed in English/Welsh and braille. We were also told that the practice leaflet would be produced in larger print on an individual basis.

Conversations with GPs indicated that hospital discharge information was much better than it had been in the past and was dealt with promptly on receipt at the practice. This meant that patients benefitted from planned continuity of care on their return home from hospital in accordance with their needs.

Timely care

Standard 5.1 Timely access

All aspects of care are provided in a timely way ensuring that people are treated and cared for in the right way, at the right time, in the right place and with the right staff.

The practice was open Monday to Friday between the core hours of 8:25am to 6:00pm and didn't close at lunchtime. The first available appointment was 8:30am each day: emergency patients being able to be seen in the practice until 6:30pm. Patients were generally required to book their appointment on the day via telephone, although patients were also able to book appointments in advance.

Conversations with the practice team revealed that they were constantly reviewing ways of improving patient access to appointments. They acknowledged, however, that patients continued to experience difficulty in getting their telephone calls answered early morning. This was due to the volume of calls made to the practice at that time of day.

We were able to confirm that the practice team were flexible in their approach to assisting patients with hearing difficulties or other sensory problems, to make appointments in person.

There was a daily telephone consultation system in place which enabled patients to receive advice about their healthcare concern. This was to try to provide patients with support and advice in a timely way. We also found telephone consultations were followed up with a face to face appointment, as and when appropriate.

The practice was not offering patients access to the My Health Online (MHOL) appointment booking service, at the time of this inspection. We therefore advised the team to consider its use in the future as a further means of assisting patients to access primary care appointments.

Patient referrals to secondary care were all made via the Welsh Clinical Communications Gateway (WCCG)[2]. We were informed that patient referrals to hospital were checked each day by a nominated member of the administrative staff to ensure that they had reached the relevant hospital destination. The system in place was considered to be robust and meant that the risk of any referrals being delayed or mislaid was minimised.

We found that there was no defined referral policy in place at the practice, each GP choosing to apply referral criteria as described within local guidance. Discussions with GPs indicated that patients were verbally informed when they should expect to receive an acknowledgement from the hospital about their referral. We did, however, advise that the practice may wish to consider offering patients written information about that, to assist them further.

[2] The Welsh Clinical Communications Gateway (**WCCG**) is a national system in Wales for the electronic exchange of clinical information such as referral letters.

Individual care

Standard 6.1 Planning care to promote independence

Care provision must respect people's choices in how they care for themselves as maintaining independence improves quality of life and maximises physical and emotional well being.

The practice premises could be accessed by stairs, or lift, although the sign indicating that a lift was available could have been displayed in a more prominent position to help patients find their way to reception.

We saw lots of posters and practice policies on view in the patients' waiting room. However, these were almost exclusively in English. The practice was therefore advised of the need to consider making information readily available in Welsh and other languages to help patients improve their quality of life and emotional well-being.

We were able to confirm that the practice's answerphone message was detailed in its advice to patients regarding how to deal with emergency and non emergency healthcare situations.

Standard 6.2 Peoples rights

Health services embed equality and human rights across the functions and delivery of health services in line with statutory requirement recognising the diversity of the population and rights of individuals under equality, diversity and human rights legislation.

Discussions held with members of the team demonstrated that the practice made every effort to work closely with other health and social care professionals and groups to support patients in the community wherever possible.

We found that the practice premises contained physical adaptations to promote patients' independence when they visited. This included wide doorways, suitable toilet facilities and the use of braille.

We saw that the practice's development plan took account of the culturally diverse presentation of its registered population and the numbers of patients with severe mental health problems.

Standard 6.3 Listening and learning from feedback

People who receive care, and their families, must be empowered to describe their experiences to those who provided their care so there is a clear understanding of what is working well and what is not, and they must receive an open and honest response. Health services should be shaped by and meet the needs of the people served and demonstrate that they act on and learn from feedback.

We found that the practice had a system in place for responding to formal concerns and handling complaints. The practice manager also described how they would attempt to address any verbal concerns raised in a prompt way.

However, the practice was not following Putting Things Right[3] (PTR) arrangements as follows:

- The concerns/complaints process needed to include reference to the local community health council and the Public Services Ombudsman for Wales as a means of informing patients of their rights to support and advice
- The practice needed to ensure that the revised complaints/concerns procedure was displayed in prominent areas of the practice to assist patients with understanding their rights
- To assist with identifying improvements needed, the practice was required to develop a mechanism for recording informal/verbal complaints and to monitor their nature and number
- The practice needed to ensure that all staff are aware of the PTR timescales for acknowledging and resolving patients' concerns/complaints about services provided at the practice

Improvement needed

The practice is required to provide a description of the action taken to ensure that it manages concerns/complaints in accordance with Putting Things Right arrangements.

We did, however, see that general information was available to patients on notice boards about how to access the local CHC advocacy service and were

[3] Putting Things Right refers to the current arrangements in Wales for raising concerns about NHS treatment.

told that the practice had not received any formal concerns/complaints in the past twelve months.

The practice did not have a Patient Participation Group at the time of inspection and there were no plans to form such a group. The practice was therefore advised of the need to consider this matter in the near future; given the importance of listening to patients and acting on any feedback received.

We saw there was a suggestions box at reception. However, this had been rarely used by patients to offer their views on service provision. In addition, there was no formal mechanism in place to seek patients' views on services provided. The practice should therefore consider formalising the process of gathering their own patient feedback so that they can demonstrate that patients are supported to provide their views on an ongoing basis. This may include alterations to the practice's website to enable patients to comment via this method.

Delivery of safe and effective care

Overall, we found the practice had arrangements in place to promote safe and effective patient care in accordance with the Health and Care Standards.

For example, there were appropriate internal communication systems in place which aimed to avoid unnecessary delays in patient care, support and treatment.

We did, however, identify the need for the practice to ensure that the outcome of all house calls were recorded within patients' records in a timely way.

Safe care

Standard 2.1 Managing risk and promoting health and safety *People's health, safety and welfare are actively promoted and protected. Risks are identified, monitored and where possible, reduced and prevented.*

We were able to confirm that a health and safety environmental risk assessment had been completed recently by an external contractor. No areas for improvement had been identified.

We were also provided with a copy of the fire safety policy and separate 'Protocol' which described the action to be taken by staff in the event of computer problems, incapacity of the practice GPs, loss of telephone system, electricity and/or gas supply. The practice manager further informed us that fire drills were conducted and recorded, so that staff were clear about their roles and responsibilities in the event of fire.

We saw that all areas of the practice occupied by patients were very well presented and maintained, pleasantly decorated, clean and uncluttered (which reduced the risk of falls within the premises).

We saw that key codes were fitted to doors of administrative offices to prevent unauthorised access. This meant that the practice recognised the importance of ensuring staff and patients' safety as well as the security of all records held at the premises.

Standard 2.4 Infection Prevention and Control (IPC) and Decontamination

Effective infection prevention and control needs to be everybody's business and must be part of everyday healthcare practice and based on the best available evidence so that people are protected from preventable healthcare associated infections.

We saw that hand washing facilities and paper hand towels were available in all clinical areas and toilet facilities to reduce the risk of cross infection and protect both patients and staff. All areas were visibly clean and fresh.

We were provided with documentary evidence of the safe storage and collection of confidential waste together with clinical and household waste. One of the practice nurses also described the clinical waste audit completed every month.

Relevant members of the practice team had received Hepatitis B vaccinations and we were able to confirm their subsequent level of immunity by looking at the information held. However, information in relation to one of the GPs was unavailable. We therefore requested that this be made available to HIW as soon as possible.

Standard 2.6 Medicines management

People receive medication for the correct reason, the right medication at the right dose and at the right time.

We discussed the local policy in place for effective prescribing with a senior GP and looked at a sample of patient records. As a result, we were satisfied that there was a robust repeat prescribing system in place and the practice was compliant with legislation, regulatory and professional guidance.

A member of the practice team described the process in place for checking resuscitation equipment, drugs and oxygen supply to ensure that staff could respond quickly to patients in the event of an emergency.

Standard 2.7 Safeguarding children and adults at risk

Health services promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.

The practice had nominated a lead GP in respect of adult and child protection and each of the GPs had completed protection of vulnerable adults training at level 3. We were also able to confirm that all staff had received training with

regard to All Wales child and adult protection arrangements and had access to a current policy and contact details for the local safeguarding team. This was, to ensure that they would know what to do in the event of the identification of a potential/actual safeguarding issue. We were informed that refresher training on this topic was made available to staff.

All staff wore identity badges to assist patients when speaking with the practice team.

Vulnerable patients were identified by means of a symbol placed on their records. This was a means of ensuring that staff were alerted to the possibility that such patients may have additional needs and support whilst at the practice and to access primary care services.

Effective care

Standard 3.1 Safe and clinically effective care

Care, treatment and decision making should reflect best practice based on evidence to ensure that people receive the right care and support to meet their individual needs.

We held conversations with GPs to determine how the clinical team kept up to date with best practice, national and professional guidance. We were told that new guidelines (including those published by the National Institute for Heath and Care Excellence (NICE)) were discussed informally between the partners.

We found that the practice was currently unable to complete new patients' record summaries in a timely way. This was because there was no member of staff assigned to this task. Given that statistics provided indicated that over 80 per cent of records had been summarised, we did not identify this as a formal improvement (this percentage deemed to be acceptable by the local health board for a non-training practice).

We did, however, advise the practice of the need to ensure that the task of summarising was delegated to a member of staff as soon as possible. This was to ensure that key information about patients' healthcare needs was readily available to clinical staff during consultations to assist with safe and effective decision-making and care planning.

Record keeping

Standard 3.5: Record keeping *Good record keeping is essential to ensure that people receive effective and safe care. Health services must ensure that all records are maintained in accordance with legislation and clinical standards guidance.*

We looked at the content of four to five patients' electronic records for each clinical member of staff and found that the practice team would have no difficulty deciding what needed to be done next. Patients' records were also seen to be detailed in terms of their medical history, examinations completed and plans of care in accordance with professional standards and guidelines.

We found that there were robust processes in place with regard to the use, sharing of, and protection of patient information at such times when house calls were made. The same robust processes applied to times when information needed to be shared between the practice and GP out of hour's service. We further found that there was a well established system in place to alert the practice team about patient deaths.

However, we discovered that there were occasions when the transfer of clinical information from house calls to the practice system was delayed. This meant that the date in the records reflected the date of entry rather than the date of the actual consultation, thereby giving an inaccurate impression of the sequence of clinical events, especially if there had been further clinical input in the intervening period.

Improvement needed

The practice is required to inform HIW of the action taken to ensure that there is no future delay in recording the outcome of house call consultations.

We were able to confirm that patients' records were stored securely, updated and were able to be retrieved in a timely way.

Quality of management and leadership

We found that the leadership provided by the GPs and the Practice Manager and Deputy respectively, resulted in a positive working culture. We also found that there were robust and well established processes and systems in place in support of the efficient running of the service.

Staff were clear about their roles and day to day responsibilities and they also told us that they felt supported by all members of the practice team.

We found that there was a training/orientation programme in place to ensure the effective induction of new members of the practice team. This meant that patients were supported by staff who had received sufficient training to become familiar with their role and practice processes. Similarly, established members of the team were provided with the opportunity to undertake regular training relevant to their work and development.

Governance, leadership and accountability

Health and Care Standards, Part 2 - Governance, leadership and accountability *Effective governance, leadership and accountability in keeping with the size and complexity of the health service are essential for the sustainable delivery of safe, effective person-centred care.*

We found that the leadership provided by the GPs and the Practice Manager and Deputy respectively, resulted in a positive culture and an organisation that placed an emphasis on continuous improvements and the delivery of safe and effective patient centred care.

Specifically, there were good governance arrangements in place in the form of up to date and relevant protocols, procedures and clear polices which underpinned the day to day work of the practice.

There was a comprehensive risk assessment programme in place; the practice being supported by an external contractor for that purpose.

GPs met together daily (on an informal basis) and staff confirmed that they were consulted on any changes made to the way the practice worked at weekly practice meetings. We were also made aware of the emphasis placed on enabling staff to make suggestions about improvements to services provided.

We were told that the GPs held regular business meetings and meeting where other members of the practice team attended. Such meetings were, however, stated as being infrequent and not always recorded.

We were able to confirm that multidisciplinary meetings took place every six weeks which were documented and contained details of discussions held, lessons learned and any action required.

Discussions with GPs and the Practice Manager revealed that there had been no significant patient events since 1 April 2015.

Staff and resources

Standard 7.1 Workforce

Health services should ensure there are enough staff with the right knowledge and skills available at the right time to meet need.

Conversations with the practice manager revealed that staff sickness levels were low. We also found that a number of staff had been working at the practice for a number of years which provided stability across the team.

We were provided with details of the induction training in place which clearly set out the key skills that staff were helped to acquire. We were also provided with details of the nature and frequency of training that staff were expected to complete on an ongoing basis.

We found that there was a system in place to provide staff with an annual appraisal. However, staff appraisals had not been completed for approximately 18 months. We therefore advised the practice of the need to address this issue to promote two way discussions with employees about aspects of their work and training needs.

Improvement needed

The practice is required to provide HIW with details of the action taken to ensure that all staff receive an annual appraisal of their work in the near future and on an ongoing basis.

5. Next steps

This inspection has resulted in the need for the GP practice to complete an improvement plan (Appendix A) to address the key findings from the inspection.

The improvement plan should clearly state when and how the findings identified at Meddygfa Albany Surgery will be addressed, including timescales.

The action(s) taken by the practice in response to the issues identified within the improvement plan need to be specific, measureable, achievable, realistic and timed. Overall, the plan should be detailed enough to provide HIW with sufficient assurance concerning the matters therein.

Where actions within the practice improvement plan remain outstanding and/or in progress, the practice should provide HIW with updates to confirm when these have been addressed.

The improvement plan, once agreed, will be evaluated and published on HIW's website.

6. Methodology

The new Health and Care Standards (see figure 1) are at the core of HIW's approach to inspections in the NHS in Wales. The seven themes are intended to work together. Collectively they describe how a service provides high quality, safe and reliable care centred on the person. The standards are key to the judgements that we make about the quality, safety and effectiveness of services provided to patients.

Figure 1: Health and Care Standards

During the inspection we reviewed documentation and information from a number of sources including:

- Information held to date by HIW
- Conversations with patients and interviews of staff including doctors, nurses and administrative staff
- Examination of a sample of patient medical records
- Scrutiny of policies and procedures
- Exploration of the arrangements in place with regard to clinical governance.

These inspections capture a *snapshot* of the standards of care within GP practices.

We provide an overview of our main findings to representatives of the practice at the feedback meeting held at the end of each of our inspections.

Any urgent concerns emerging from these inspections are brought to the attention of the practice and the local health board via an immediate action letter and these findings (where they apply) are detailed within Appendix A of the inspection report.

Appendix A

General Medical Practice: Improvement Plan

Practice: Meddygfa Albany Surgery

Date of Inspection: 23 February 2017

Page number	Improvement needed	Standard	Practice action	Responsible officer	Timescale
Quality of the patient experience					
9	The practice is required to inform HIW of the action taken/to be taken to ensure that non clinical staff are made aware of what is expected of them when they are requested to act as a chaperone.	4.1	We want to ensure that all non-clinical staff are trained formally as chaperones, and that they are aware of what is expected of them when asked to act as a chaperone. Training will be delivered in conjunction with the NHS Clinical Governance Support Team “Model Chaperone Framework” and will ensure the non-clinical chaperone has awareness of the mechanisms involved for raising concerns. All staff will receive a copy of this	Partners	9/5/2017

Page number	Improvement needed	Standard	Practice action	Responsible officer	Timescale
			document to enable them to refer to it when required. Training will ensure that all non-clinical staff have reassurance and skills and confidence to carry out the role required of them. This training will safeguard both parties, the clinician and the patient, and the non-clinical staff member will be able to determine that continuing consent is in place should any concerns be raised. The staff bear witness to an intimate procedure and will have the training to decide what is appropriate during the consultation. This goal is achievable, and all staff have readily agreed to the Formal Chaperone training which will be delivered on the 9th May 2017 in protected practice time. This will further support the practice and underpin annual training for		

Page number	Improvement needed	Standard	Practice action	Responsible officer	Timescale
			Safeguarding, most recently delivered on the 4th April 2017, reinforcing current knowledge and existing confidence and awareness. Staff are motivated in ensuring that they attain the required skills and knowledge, and feel they can further support the practice and add to their own skill set. The training is relevant to what has been identified as it is following best practice and protects all parties concerned. Non-clinical staff can reasonably be expected to carry out this new duty with training, further knowledge and ongoing support. The training will reinforce current knowledge and underpin safeguarding training ensuring correct protocols are followed, and all risks minimised. The training will be delivered on the 9th May 2017 and will be followed by		

Page number	Improvement needed	Standard	Practice action	Responsible officer	Timescale
			regular update training when required. The practice has regular CPET protected time dates, with rolling annual training. Chaperone training will now be added to the regular annual training that is delivered to the team by external trainers ensuring we comply with current legislation.		
13	The practice is required to provide a description of the action taken to ensure that it manages concerns/complaints in accordance with Putting Things Right arrangements.	6.3	The practice concerns/complaints process needs to include reference to the local Community Health Council and the Public Services Ombudsman for Wales, to ensure patients are fully informed of their right to support and advice. This advice and the procedures which can be followed by the patient need to be displayed in prominent areas within the practice for ease of access.	Managing Partner / Senior Receptionist	April 2017

Page number	Improvement needed	Standard	Practice action	Responsible officer	Timescale
			Patients will be able to identify the relevant route of their complaint and be provided with the correct information required if they feel the need to escalate their concern or seek further advice and support. These options will enable the patient to be aware of what processes to follow, and will ensure that they have access to all appropriate and relevant avenues in order to highlight their concern/complaint further if needed. This objective is achievable as some amendments will need to be put in place on display boards in the practice and in the patient leaflet and written information and literature. This will be in place by May 2017, with all necessary amendments completed. This information will be shared with the patient and will clarify their rights		

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			with regard to the processes involved in the complaints process. The “Putting Things Right” leaflet will be displayed on the practice notice board and copies will be readily available in the waiting room. A new process has already been implemented at the suggestion of HIW, and is already producing results. The practice has developed a mechanism for recording informal verbal complaints, and appointed a specific named complaints advocate (Senior Receptionist) to ensure the partners are not always the first to deal with a concern. This enables the complaint to be escalated if necessary and investigated by a different person for an unbiased viewpoint. This further enables the practice to measure results and identify if there is a pattern to the complaints, enabling us to monitor their nature and number, and		

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			address common areas. A new form has been developed to capture this information and it has been cascaded to all staff. Training will be provided for the Senior Receptionist to update her complaints handling skills. This process is already in place, as of April 2017, with all relevant information cascaded to the staff. Staff are aware of the “Putting Things Right “process, with our objective being to follow these guidelines for all complaints. We wish to acknowledge and resolve all patient concerns and complaints within the recommended timeframe and act upon improvements which were identified, and target concerns as necessary.		

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Delivery of safe and effective care					
18	The practice is required to inform HIW of the action taken to ensure that there is no delay in recording the outcome of house call consultations.	3.5	We need to ensure that home consultations are recorded electronically by the GP and a thorough paper trail and process is in place. This will ensure that there are no delays, and that the date in the patient records reflects the date of the consultation rather than the date of entry. The sequence of clinical events needs to be accurate, contemporaneous and specific should the records ever need to be referred to at a later date. This new process has been discussed and agreed with all the GPs and partners, and will take immediate effect. A thorough paper trail will now be in place ensuring these new processes minimise risk clinically and ensure that all concerns and queries are recorded should other agencies become	GP/clinicians	April 2017

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			involved, such as the Coroner. This will reinforce safe and effective care and reflects best practice. This is easily achievable with all clinicians agreeing to this new process and being very much engaged in improving processes and procedures within the practice. Historically, home visits had been recorded after the event, hence highlighting a weakness in the way in which house calls were recorded. Going forward the new process will ensure a more robust fail safe process when recording house calls on the system. It is imperative to have an accurate record of clinical findings as this will improve record keeping and the care that is offered. This new system will result in precise accurate record keeping of a home visit by the GP should other authorities seek sight of patient		

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			records. This also reduces the chance of error due to handwritten notes, which can often be difficult to decipher, especially by another clinician. This is a realistic decision and one that was readily agreed upon, as it results in good record keeping and contemporaneous notes. A training course will also be accessed for “good record keeping” by the clinician to further uphold this new process. This new process has been introduced with immediate effect – April 2017. The previous process, as highlighted portrayed an inaccurate record, as the records reflected the date of entry by the clinician rather than the date of the actual consultation, thus giving an inaccurate impression of the sequence of events.		

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Quality of management and leadership					
20	The practice is required to provide HIW with details of the action taken to ensure that all staff receive an annual appraisal of their work in the near future and on an ongoing basis.	7.1	The staff appraisals are overdue and have not been completed for 18 months due to time constraints and staff shortage. We have addressed this, and protected time has been scheduled in May 2017 to complete all staff appraisals. Extra staff will cover the time required as this has been timetabled in to the working day. It is important to ensure that all staff are listened to and further development encouraged. The right person has to be in the right job, and it is vital that staff feel invested in emotionally as well as financially by the practice. Informal conversations do take place but specific goals need to be planned and discussed for the further development of the team. Appraisals will be tailored for the individual staff member and further	Managing Partner	May 2017

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			training identified if necessary. This can be evaluated and measured by increasing their skills and confidence. The practice is very training orientated with each staff member attending protected training days every 6 weeks, but individual appraisals will identify any gaps in learning and this can generate motivation and a feeling of self worth for the individual. During the appraisal process actions will be put in place for the individual as well as a personal training plan if identified and robust time scales. Investing in the team ensures staff have the skills, ability and knowledge to offer the best possible patient care and support the practice. Performance targets can be discussed and goals put in place for further development where necessary. Currently informal consultations do ensure training		

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			needs are met but there may still be gaps that need identified. It is a positive strength that many staff are long term employees of the practice, ensuring a good rapport, strong morale and knowledge of the sector which strengthens continuity of care. All staff are agreed that this is a valuable exercise and embrace the time spent discussing their role at previous appraisals. Time needs to be realistically scheduled to ensure the appraisals and further training and learning are accomplished. The practice fully supports this and allows staff cover and study leave / protected time for anyone who wishes to attend a course or training programme. Action plans and specific timescales can be put in place and this will ensure, by careful planning, that the goals aimed for are realistic and achievable. This will be addressed		

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			in May 2017 with cover already in place, although the practice needs to be realistic in terms of timescales and staff absence at any one time. Regular group training has proven valuable and is always relevant to the role of the staff member and practice. Training needs can be tracked and measured over time and steps put in place to achieve goals. Some nursing courses are planned ahead of time, and these are always booked in advance if further training in this area is required. This enables us to plan comprehensive training around the needs of the practice but still supporting the member of staff. Courses are easily accessed and staff are encouraged to book any that they feel will be valuable for them. The practice always funds courses and files are kept for staff with their training certificates and		

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			learning plans. This enables us to measure what training has been cascaded in a given time frame and identify any further gaps.		

Practice representative:

Name (print): .....Angela Harris-Kirkwood.....

Title: .....Managing Partner.....

Date: .....20 April 2017.....