Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection (Announced)

Glyn Ebwy Surgery / Aneurin Bevan University Health Board

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Contents

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales are receiving good care.

Our values

- **Patient-centred: we place patients, service users and public experience at the heart of what we do**
- **Integrity: we are open and honest in the way we operate**
- **Independent: we act and make objective judgements based on what we see**
- **Collaborative: we build effective partnerships internally and externally**
- **Professional: we act efficiently, effectively and proportionately in our approach.**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care.**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice.**
Influence policy and standards:	**Use what we find to influence policy, standards and practice.**

1. What we did

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Glyn Ebwy Surgery, James Street, Ebbw Vale, NP23 6JG within Aneurin Bevan University Health Board on the 16 May 2017.

Our team, for the inspection comprised of a HIW inspection manager (inspection lead), GP and practice manager peer reviewers, a lay reviewer and a clinical leadership fellow[1] (observer).

HIW explored how the service met the Health and Care Standards (2015).

Further details about how we conduct GP inspections can be found in Section 5 and on our website.

[1] Clinical research fellows are medical students who take one year out of their training to undertake projects/research to equip them with the knowledge and skills to become medical leaders of the future. The programme is overseen by the Wales Deanery in association with NHS Wales, the Welsh Government, the Royal College of Surgeons (Ed) other health related organisations.

2. Summary of our inspection

Overall, we found evidence that Glyn Ebwy Surgery provided safe and effective care. However, we found some evidence that the practice was not fully compliant with all Health and Care Standards in all areas.

This is what we found the service did well:

- Overall, patients we spoke with were happy with the service provided
- There were excellent links with voluntary and carers' organisations
- There were arrangements in place to promote safe and effective patient care across areas
- Staff we spoke with felt well supported and were happy in their roles.

This is what we recommend the service could improve:

- Staff's awareness of, and the practice's compliance with, health and safety law and policy required improvement. This includes ensuring there is an up to date fire risk assessment in place
- Ensuring there is appropriate equipment and stock of medicines for managing medical emergencies and that all staff are up to date with mandatory CPR training
- Improvements were needed to the system of prescribing medicines to ensure systems were sufficiently robust
- Improvements were needed to ensure appropriate recording of patient safety incidents and significant events took place and that a culture of reporting and learning was promoted in this regard
- Some aspects of workforce management required improvements e.g. recording staff checks, ensuring mandatory training was completed in a timely way and induction resources
- There was a need for improvement activities and shared learning to be encouraged and evidenced.

3. What we found

Background of the service

Glyn Ebwy Surgery currently provides services to approximately 7,000 patients in the Ebbw Vale area. The practice forms part of GP services provided within the area served by Aneurin Bevan University Health Board.

The practice employs a staff team which includes three GP partners, two practice nurses (currently one vacancy which had been filled), one phlebotomist, one practice manager, and a number of administrative and reception staff. The practice had been trying to recruit another GP but had not been successful in a recent recruitment period.

The practice provides a range of services (as stated on their website), including:

- Travel vaccinations
- Cervical smears
- Family planning
- Smoking cessation
- Private medical examinations.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

Overall, patient satisfaction in this practice was high.

We found people were treated with dignity and respect. Information was available to support patients to stay healthy and mechanisms were in place to support carers. There were excellent links with voluntary organisations.

Several aspects of the environment required review to ensure that patient privacy was maintained and that working practices were accessible to all patients.

Overall, we found appropriate internal communication and organisational systems in place. However there was a need to review aspects of referrals and discharge information to ensure systems were sufficiently robust.

Overall patients were satisfied with the appointments system in place.

The practice had a system in place to enable patients to raise concerns/complaints but complaints information should be made more visible in the waiting area. There were mechanisms in place to allow patients to provide feedback.

During our inspection we distributed HIW questionnaires to patients to obtain their views on the service provided at the practice. In total, we received nine completed questionnaires. The majority of completed questionnaires were from patients who had been a patient at the practice for more than two years. We also spoke informally with patients to obtain their views. Overall, patient feedback was positive. Patient comments included the following:

"They do a wonderful job here"

"Lovely staff"

"Very happy with the practice"

Staying healthy

There was information available to help patients to take responsibility for their own health and well being and excellent links to carers' support services.

There was a range of health promotional materials available for patients, provided through leaflets and posters in the waiting area with a small amount of health promotion information also available on the practice's website. There was good information about local services. This meant that patients could access information to support them in taking responsibility for their own health and wellbeing. We suggested the practice consider grouping the materials into different areas/themes to make it easier for patients to find information.

The practice maintained a carers' register. There was information displayed about support and services for carers, including local services. One member of staff acted as a carers' champion to promote best practice. It was also positive to note that the local carers' advice service provided drop in surgeries at the practice to raise awareness of the services and support available.

We saw that additional services were provided to support patients in a holistic way including counselling services and strong links to voluntary organisations, including, for example, the Citizens Advice Bureau who were able to see patients at the surgery.

Dignified care

We found that people were treated with dignity and respect by staff.

Every patient who completed a questionnaire felt that they had been treated with respect when visiting the practice. We observed staff greeting patients both in person and by telephone in a polite, friendly and welcoming manner. Staff were sensitive and caring and we saw staff going out to patients in the waiting area to assist where needed.

Doors to individual consultation and treatment rooms were kept closed when staff were attending to patients. This meant staff were taking appropriate steps to maintain patients' privacy and dignity during consultations.

We considered the physical environment and we found that patient confidentiality and privacy had been considered and the physical environment had been adapted to support this. For example, the reception area was separated from the waiting area by a built up desk which enabled documents to

be shielded from view. Staff could attend to patients using wheelchairs by leaning over the desk or walking around to the waiting area. There was some space behind reception that was also shielded from view and gave privacy to staff using the telephone. Staff also told us that they could use other areas of the practice, for example, an empty consultation room to discuss any sensitive issues with patients to maintain confidentiality.

Despite this, we found that conversations could be overheard, due to the physical layout and soundproofing of the building. This was particularly noticeable when sitting in the part of the waiting area directly outside the phlebotomist and treatment rooms. We found that it was possible to hear patient conversations from within the phlebotomist's room. The practice must consider how to protect patient privacy in this regard, for example, through consideration of piped music or further adaptation to the environment.

There was a written policy on the use of chaperones. There were times when non clinical staff acted as chaperones and they had received training in this role. This meant that there were working arrangements in place which aimed to protect patients and practice staff.

Improvement needed

The practice must ensure that patient confidentiality and privacy is protected at all times. Specifically, measures must be put in place to prevent conversations from being overheard in the waiting area when patients are being seen in the treatment/phlebotomists' room.

Patient information

Information for patients about the practice's services was available within a practice leaflet. This provided a wide range of useful information about the practice. Information was also displayed in the waiting area. In addition there was also a practice website which was an excellent, up to date, comprehensive source of information. All patients completing questionnaires (except for one) knew how to access out of hours GP services and we saw that this information was visibly displayed.

We were told that the practice leaflet could be produced in other formats and languages on request, including large print and audio. We advised the practice to make information available in Welsh and other formats according to the needs of the practice population. The practice should consider proactively how to make their practice leaflet more accessible to those patients who speak different languages or those patients requiring other accessible formats.

Our informal discussions with patients indicated that patients felt that doctors and nurses were good at explaining their care.

Improvement needed

The practice must ensure that information is provided in a language and format that meets the needs of patients, including those patients who speak Welsh.

Communicating effectively

Staff told us that they could use interpreting services when needed. The practice had a hearing loop which they had just installed and planned to use to aid communication with those patients with hearing difficulties. We advised that staff should be fully trained on using this.

We saw that a tannoy system was currently used to call patients into appointments. The sound quality was not always clear. We saw that patients were not always able to hear this (particularly where they had hearing difficulties) or understand the name being called. Although patients did not miss appointments as a result, this led to delays with staff having to come out into the waiting area and prompt patients.

None of the patients who completed a questionnaire considered themselves to be a Welsh speaker so it was not possible to find out how often patients had been able to speak to staff in Welsh. All patients, however, indicated on the questionnaire that they were always able to speak to staff in their preferred language.

Patients were asked on the questionnaire whether they are asked questions about their medical problem when they try to make an appointment; there was a mixed response to this question, with just over half of patients answering yes, and the rest of the patients answering no. All but one of the patients who answered yes said that they understood why they were asked questions about their medical problem when they try to make an appointment.

The practice had established systems for the management of external and internal communications. Arrangements were in place to ensure clinical information received at the practice was recorded onto patients' records and shared with relevant members of the practice team in a timely manner, including correspondence, test results and out of hours information. There was a system for recording any patient deaths.

There were messaging systems in place which aided communication between staff members.

Staff told us that information relating to hospital discharge was recorded onto patient records in an adhoc way, without a system being in place to ensure key information from all discharge summaries was transferred and therefore made readily available and visible, to staff.

Improvement needed

The practice must review use of the tannoy system for calling patients into appointments to ensure there is a system in place that is accessible for all patients, including those with hearing difficulties.

The practice must review the system for recording hospital discharge information on patient records and ensure that this is done consistently, and made clearly visible in all patient records on an ongoing basis.

Timely care

All of the patients who completed a questionnaire said that they were very satisfied with the hours that the practice was open. We saw that the surgery tried to accommodate patients outside of office times and was open from 8am until 6.30pm Monday to Friday.

Patients were able to book appointments in person, by telephone and online. The majority of patients who completed a questionnaire said that it was either very or fairly easy to get an appointment when they needed it. When asked in the questionnaire to describe their experience of making an appointment, all patients said that it was either very good or good. We saw that staff were forthcoming with information about how many patients were ahead of the person booking in, so that patients had an idea of how long they may have to wait.

Patients could book urgent appointments on the same/next day and routine appointments were available up to two weeks in advance. Staff told us that they would always try to accommodate anyone who had an urgent need for an appointment on the same day.

The nursing team ran a number of clinics for patients with chronic health conditions so that they could access the care and treatment they needed without having to see a doctor.

There was a referral policy in place which guided staff in making referrals. Staff told us that there was not currently a system in place to ensure referrals had been received and acted upon and referral rates were not currently audited within the practice.

Improvement needed

The practice must ensure there is a robust system in place to monitor and record referrals, ensuring that they have been received, particularly where these are urgent. Staff should consider auditing referrals with a view to reviewing current systems and improving practice where this may be possible.

Individual care

Planning care to promote independence

We found that patients, who required them, were offered regular personal health checks, including vulnerable patients and those with additional needs, for example, patients with learning disabilities and mental health difficulties. We saw that regular multi-disciplinary team meetings were organised where this was appropriate in planning patients' care, for example, for those patients requiring palliative care.

We saw that those patients with additional needs were flagged on the electronic system as a way to alert staff. Staff told us they offered longer appointments to patients where required, in order to meet their individual needs.

People's rights

Staff described a number of ways in which they endeavoured to meet patients' individual needs throughout the patient journey.

We saw that patients' rights regarding data collection was explained on the practice's website. We suggested that the practice also advertise this in their waiting areas. Staff had all signed confidentiality agreements which showed they had been made aware of their responsibilities around protecting patients' personal information.

Listening and learning from feedback

The practice had a written procedure in place for patients to raise concerns and complaints. The written procedure was comprehensive and fully compliant with 'Putting Things Right' requirements, the current arrangements for dealing with concerns (complaints) about NHS care and treatment in Wales. This included

information about how to access Community Health Council (CHC) as an advocacy service with making complaints.

There was a lack of complaints information on display in the waiting area apart from some generic 'Putting Things Right' leaflets. This meant, overall, that access to this information could be improved for those patients visiting the practice. Patient questionnaires reflected this and two thirds of patients who completed a questionnaire said that they did not know how to raise a concern or complaint about the services they receive at the practice. There was full and comprehensive complaints information on the website.

We saw that staff maintained records of complaints and from the records we saw, these had been dealt with within specified timescales, or where a timescale had been missed, a full explanation had been given to the patient.

There were systems and mechanisms in place to allow patients and carers to provide feedback on services. There was a suggestion box and staff carried out annual questionnaires with patients. Staff told us that they made changes as a result of listening to feedback, for example, implementing the self check in machines. We suggested staff also consider how to communicate back to patients the changes they had made as a result of listening to their feedback.

Improvement needed

Complaints information should be visibly displayed and easily accessible for patients.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

Overall, we found the practice had arrangements in place to promote safe and effective patient care, although attention was required in terms of some health and safety requirements and in ensuring internal systems were sufficiently robust.

We have asked the practice to make improvements to health and safety and risk management across a number of areas. This includes ensuring there is an up to date fire risk assessment in place and that there is appropriate equipment and medicines to manage medical emergencies.

We found suitable infection control arrangements in place and although the policy required some attention, we saw that improvements were being made in practice, in this area.

Improvements were needed to the system of prescribing medicines to ensure systems were sufficiently robust.

There were comprehensive child and adult protection policies in place but we could not be assured that staff had completed up to date training in these areas.

Improvements were needed to ensure appropriate recording of patient safety incidents and significant events took pace and that a culture of reporting and learning was promoted in this regard.

The sample of patient records we reviewed were of a good standard with some aspects which could be improved.

Safe care

Managing risk and promoting health and safety

Patients were asked how easy they found it to get into the building that the GP practice is in. The majority of patients who completed a questionnaire felt it was easy to get into the building. However, a comment received on the

questionnaires indicated that access to the building for wheelchair users was not very easy:

> *"Difficult to get in and out of the front door. There is a bit of a ramp and 2 doors to negotiate which don't have an opening system."*

Our observations on the day confirmed that patients (particularly those with pushchairs or using wheelchairs/with mobility needs), at times struggled with access, in ways as indicated in the comment above. The practice should review this with a view to making improvements. We saw that all patient services were provided on the ground floor which meant that patients did not have to negotiate stairs once inside the building and disabled toilet facilities were available. There was clear signage to direct patients.

During a tour of the practice building, we found all areas occupied by patients to be clean and uncluttered which reduced the risk of trips and falls. The practice building was suitably maintained externally and internally.

Although there were guidelines available and some individual policies covering aspects of health and safety, there was not currently an overall health and safety policy in place. A policy covering all mandatory areas is required to ensure all staff are aware of, and fulfilling their duties regarding health and safety law and that the practice is compliant. We advised staff to consult the Health and Safety Executive to ensure they complied with all relevant health and safety requirements.

We found that there was a display screen equipment policy held at the practice. However, staff had not been offered a formal risk assessment of their office work station/desk area or support as to how to complete an individual assessment.

We saw that an environmental risk assessment had been undertaken in February 2017 to ensure that risks within the practice environment had been fully assessed and actions monitored and taken to minimise them. There was a system in place in regards to the Control of Substances Hazardous to Health (COSHH).

We saw that some fire safety equipment had been installed very recently, for example, fire extinguishers. The fire logbook showed that fire alarm checks took place monthly. There was a requirement for a formal programme of scheduled inspections and checks to be implemented for all fire equipment on an ongoing basis. The practice must take advice around this to ensure they comply with fire safety legislation.

We found that a fire risk assessment was not in place, as required under health and safety regulations. This meant we could not be assured that fire risks had been fully considered to maintain patient and staff safety within the practice environment. Our concerns regarding this were dealt with under our immediate assurance process. This meant that we wrote to the practice immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in Appendix B.

We found that business continuity risks had been considered and plans put in place to manage risks. However, we found three different business continuity plans around the practice with differing information and there was a need for all information to be captured in one central, clear, up to date policy. We found there was a lack of a practice risk register to formally review practice risks.

We checked emergency equipment and emergency drugs at the practice to explore how medical emergencies were managed. We found significantly out of date stock in the resuscitation equipment bag including ambubags, airway adjuncts, needles, cannulae and manual suction device. We could not be assured that there was an appropriate system in place for obtaining medicines for use as emergency drugs. We could not be assured that the current stock of emergency drugs would allow for safe practice in managing medical emergencies. The practice could not demonstrate that it had considered the appropriateness of all the drugs stocked nor the methods that would need to be used in administering them in an emergency. We also found one loose sheet of medication (without date). Staff had last completed CPR training in April 2016 and were due to complete this again in September 2017. Annual updates are recommended. This leaves a gap of five months between April – September 2017 when staff will not be up to date in terms of mandatory yearly updates. Our concerns regarding these points were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B/

Improvement needed

The practice should review access to the building to ensure that the difficulties experienced by patients using wheelchairs are resolved.

There was a requirement for a formal programme of scheduled inspections and checks to be implemented for all fire equipment on an ongoing basis. The practice must take advice around this to ensure they comply with fire safety legislation.

The practice must ensure that a fire risk assessment, carried out by an appropriately competent professional, is completed as soon as possible. Fire risk assessments should be kept up to date, monitored, with actions implemented to minimise risks within the environment on an ongoing basis.

Staff must ensure that business continuity plans contain the most up to date information about how to manage risks.

The system for obtaining medicines to use as emergency drugs requires review to ensure it is appropriate.

The contents of the emergency drugs box require full review to ensure it allows for safe practice in managing medical emergencies. The practice must take advice regarding the contents of the box to ensure there are appropriate medicines to manage adult and paediatric emergencies. Loose medication in the box must be removed. Out of date needles and cannula must be removed.

The practice must ensure there is a system in place to check, monitor, review and replace (where needed) emergency equipment and emergency drugs stock on an ongoing basis.

The practice must ensure that staff keep up to date with CPR training. Staff must assess the risks involved in the 5 months' gap in annual update training and ensure the team are sufficiently trained to handle medical emergencies through this time.

Infection prevention and control

We found the practice environment to be clean. The majority of patients who completed a questionnaire felt that, in their opinion, the practice was very clean.

Staff confirmed they had access to personal protective equipment, such as gloves and disposable plastic aprons, to reduce cross infection. The clinical treatment areas were visibly clean. Hand washing and drying facilities were provided in clinical areas and toilet facilities. Hand sanitisers were also readily available around the practice.

We saw that waste had been segregated into different coloured bags/containers to ensure it was stored and disposed of correctly. There was a system for clinical waste to be securely stored until it could be safely collected.

There was an infection control policy in place which required review to ensure it was complete. However, there were linked detailed policies covering a number of aspects of infection control which provided further detail to govern staff's

working practice. Staff told us that infection control training took place but this was not always formally recorded. We advised staff to record this as an audit trail. An infection control audit was currently being completed to raise awareness of any infection control risks within the environment. We saw that changes had been made as a result, for example, use of disposable curtains in treatment rooms. Carpet in clinical areas was planned to be replaced with more easily washable flooring. The lead nurse for infection control had recently left and we advised the practice to consider how best practice would continue to be implemented.

Senior staff told us that all clinical staff were expected to ensure they received Hepatitis B vaccinations. There was a central register in place to record this.

Improvement needed

The infection control policy requires review to ensure it is complete. Staff should be trained in infection control and evidence of this should be recorded.

Medicines management

We found that the arrangements for the safe prescribing of medicines to patients required review, to ensure systems were suitably robust.

There was a health board pharmacist who provided support to the practice on an adhoc basis and supported the practice with audits.

Patients could access repeat prescriptions by calling into the surgery in person, and by post.

Staff told us that there was no formal system in place to ensure that medicines that were no longer needed, were removed from the repeat prescribing list and staff were not clear about the formulary[2] currently in use.

We saw that prescribing errors, although captured in patient notes, were not always reported as significant events. Staff also told us that concerns about adverse reactions to drugs were also not currently reported. This meant that

[2] The formulary lists all medicines approved for use in primary and secondary care

appropriate reporting was not taking place and any learning from these incidents was not being shared.

Improvement needed

Staff must ensure there is a system in place to remove medicines that are no longer needed from the repeat prescribing list.

Staff must be aware of, and have knowledge of, the formulary to which they are working. The practice must confirm with HIW which formulary they are currently working with.

Staff must report prescribing errors as significant events and must report adverse reactions to drugs.

Safeguarding children and adults at risk

There was a child protection and protection of vulnerable adults (POVA) policy in place which were comprehensive, up to date and included local contact numbers for reporting.

We saw that some staff had not completed child protection and adult protection training. Senior staff told us that clinicians completed safeguarding training on study days but were not able to confirm if clinicians had received training up to level three (which is now a requirement). We could not be assured, therefore, that all staff had completed appropriate levels of training according to their role.

We looked at the process in place for flagging child and adult safeguarding cases on the electronic system and we found these to be appropriate. We saw that multi-disciplinary working took place around child safeguarding concerns and there were regular meetings to share information and discuss cases.

Improvement needed

The practice must ensure that all staff receive up to date child protection and vulnerable adults training at a level appropriate to their role. This includes all staff, with clinicians now required to receive safeguarding training up to level three.

Effective care

Safe and clinically effective care

There were systems to facilitate the reporting of patient safety incidents and significant events. However, we found in practice, a culture of low reporting and we could not be assured that issues or events of concern were being appropriately reported as significant events.

Staff kept records of significant events and we saw that only two had been reported in the last year. Through our review of records and the prescribing system we found that a recent prescribing incident had been recorded in the patient's notes but had not been reported as a significant event. We found there was a reluctance to report and therefore a low level of reporting from the practice. This meant that any learning that could happen as a result of patient safety incidents or significant events was not being disseminated through the practice team, due to incidents not being appropriately shared and reported.

Where significant event meetings took place, this included the members of staff involved. However, there wasn't currently a formal system for disseminating any learning to the wider team following this meeting and we advised staff to consider how they could share learning and encourage service improvements in this way.

There was a system in place for patient safety alerts to be sent to clinicians where these were relevant for primary care. Staff told us new National Institute for Health and Care Excellence (NICE) guidelines were not formally discussed and we suggested the practice consider implementing this.

Improvement needed

The practice must ensure that they report all patient incidents and significant events appropriately. A culture of learning around incidents should be encouraged and promoted.

Record keeping

We looked at a random sample of electronic patient records and, overall, found a good standard of record keeping.

The records we reviewed were up to date, complete, with a good level of detail. Records included all the key basic information required such as date, time, identity of the inputter etc. which ensured a clear audit trail.

We found that clinicians were consistently recording when they obtained patient consent. We reviewed the consent policy and found that this required updating to ensure it was up to date with the most recent legislation and case law, e.g. Montgomery judgement[3].

We found that drugs prescribed to patients were not consistently linked to conditions and this required improvement.

Overall the coding of patient records required review to ensure there was consistency. We found that not all new morbidity, problems or risk factors were Read[4] coded consistently.

Where patients suffered from significant and long term conditions we found that records included full summaries of these conditions, which meant useful background information was available to inform consultations.

There was clear recording around the indications and discontinuation of medication.

Overall, notes contained sufficient detail of consultations between clinical staff and patients and it was possible to determine the outcome of consultations and the plan of care for the patient. However, we found that patient summaries overall, required review to ensure consistency in the quality.

There was evidence to show that patients were involved in treatment decisions, however, little evidence of written information being offered to patients. Staff assured us that they did this but did not always record it. We advised to record when this was done to support an audit trail.

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[3] The Montgomery Judgement is a Supreme Court judgment which changed the law on informed consent. Doctors must now ensure that patients are aware of any “material risks” involved in a proposed treatment, and of reasonable alternatives, following the judgment of the case Montgomery v Lanarkshire Health Board.

[4] Read codes are the standard clinical terminology system used in General Practice in the UK. It supports detailed clinical encoding of multiple patient phenomena including: occupation; social circumstances; ethnicity and religion; clinical signs, symptoms and observations; laboratory tests and results; diagnoses; diagnostic, therapeutic or surgical procedures performed; and a variety of administrative items.

We saw that records were not reviewed or audited in terms of quality and we suggested the practice consider doing this to further encourage good standards of record keeping and as a way of learning and improving practice.

Improvement needed

The consent policy must be updated to ensure it is up to date with the most recent legislation and case law, to govern working practices e.g. Montgomery judgement.

The practice is required to demonstrate how improvements to record keeping will be made in the areas as identified in the report including:

- Consistent linking of drugs prescribed to patient's condition.
- Consistent Read coding
- Patient summaries require review to ensure consistency of quality
- Recording when patients are provided with written information

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how services review and monitor their own performance against the Health and Care Standards.

There were clear lines of management and accountability at the practice. There was a need for improvement activities and shared learning to be encouraged and evidenced. Improvement was required in ensuring current policies were easy to access, updated, and communicated to staff on an ongoing basis.

We found a patient-centred staff team who told us they were well supported. We advised the practice to ensure that annual appraisals took place for all staff, that checks for new members of staff were recorded and that staff undertook mandatory training in a timely way. Induction resources and packs could also be improved.

Governance, leadership and accountability

There was a practice manager who managed the day to day running of the practice and clear lines of management and accountability. We found a staff team who were committed to providing the best services possible to their patients. Some staff had been working at the practice for many years and so provided a degree of consistency. Staff were positive about the support they received from management staff. Staff told us they felt the working environment was an open one and they had confidence that any issues they raised were resolved.

Staff told us they felt able to raise concerns and there was an up to date whistleblowing policy in place which identified routes for staff to do so.

The practice had a range of relevant written policies and procedures to guide staff in their day to day work. However, we found some duplication of policies and staff were not always clear regarding which one governed their working practices. Some further organisation of policies, procedures and records was also required to allow ease of access. We could not be assured that policies were regularly communicated to staff.

Some staff working within the practice took on dual roles. This meant that staff could provide cover for each other during absences, reducing the risk of disruption to services for patients.

We saw that practice meetings took place monthly to help facilitate communication between the team. Although management staff described challenges in ensuring that all staff could attend these meetings, staff were able to feed into the meetings in other ways and minutes were available to view. We found that there was a lack of a formal meeting/forum in which to discuss clinical cases and this was done on a more informal basis between clinicians. As a result there was a lack of evidence of the discussion of clinical areas and/or sharing of learning from incidents or best practice, relating to patient care. We advised the practice to consider formalising and recording clinical discussions.

The practice had a Practice Development Plan which they had developed through their NCN[5]. This clearly identified the practice's aims and we could see that progress had been made across a number of areas. There was currently a lack of peer review, due to pressures involved in meeting patient demand. Given the improvements we have identified across a number of areas, we advise the practice to encourage and record improvement activities, peer review and shared learning.

Senior staff attended the NCN meetings and used this forum as a way to generate quality improvement activities and to share good practice. The nursing team also attended practice nurse meetings which involved an element of continued professional development and helped to keep them informed of practice developments.

Improvement needed

The practice should ensure that duplicate/old policies are removed and current policies are easy to access for all staff, updated, and communicated to staff on an ongoing basis.

[5] Neighbourhood Care Network is the term used for practice clusters within Aneurin Bevan University Health Board. A practice cluster is a grouping of GPs and Practices locally determined by an individual NHS Wales Local Health Board.

The practice must consider how to share, encourage and promote learning, including peer review, and audit and improvement activities. There must be mechanisms in place to evidence that clinical discussions and learning takes place.

Staff and resources

Workforce

Discussions with staff and a review of policies and small sample of staff records indicated they had the right skills and knowledge to fulfil their identified roles within the practice.

At the time of the inspection, there was a vacancy for one GP. A recent recruitment drive had been unsuccessful in appointing to the post and staff shared the challenges of recruiting doctors to the area. Cover was being provided by locum doctors. Aside from this, there was a stable staff team.

Staff were able to describe their roles and responsibilities and indicated they were happy in their roles. We found that annual appraisals were not happening for all staff. Yearly appraisals must be carried out to give staff the opportunity to receive feedback on their performance, to discuss training needs and indicate if any additional support is needed.

We looked at the Human Resources (HR) and recruitment documentation in place and found that there was a recruitment policy and procedure in place and appropriate checks were carried out prior to employment. We found that checks for new members of staff were not consistently recorded and we advised staff to do this to ensure there was a sufficient audit trail.

There was a process in place to induct new members of staff. Feedback we received from across staff members was variable regarding induction processes. We found that the locum pack referred to another (unrelated) GP practice. This required adaptation to ensure that it provided useful comprehensive information for locum doctors.

All staff we spoke with confirmed they had opportunities to attend relevant training. The practice manager had implemented a system whereby mandatory training was monitored and recorded across all staff. This meant that management staff were able to see, at a glance, where there were gaps in training and where staff required updates. We could see that staff had made a

start on completing mandatory topics. This required attention to ensure that staff completed all mandatory topics as soon as possible.

Improvement needed

All staff must receive annual appraisals.

Relevant checks for all new members of staff must be recorded.

The practice must ensure that staff are given sufficient support through the induction process. The locum GP pack must include comprehensive, useful information about the practice to help guide locum GPs.

Staff must ensure that mandatory training is completed in a timely way.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measureable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

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

5. How we inspect GP practices

GP inspections are usually announced. GP practices will receive up to 12 weeks notice of an inspection. This is so that arrangements can be made to ensure that the practice is running as normal, and that the inspection causes as little disruption to patients as possible.

Feedback is made available to practice representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

We check how GP practices are meeting the Health and Care Standards 2015. We consider other professional standards and guidance as applicable.

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

Further detail about how HIW inspects the GP practices and the NHS can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection.			

Appendix B – Immediate improvement plan

Service: Glyn Ebwy Surgery

Date of inspection: 16 May 2017

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
Finding – Fire risk assessment: We found that a fire risk assessment was not in place, as required under health and safety regulations. This meant we could not be assured that fire risks had been fully considered to maintain patient and staff safety within the practice environment. Improvement needed: The practice must ensure that a fire risk assessment, carried out by an appropriately competent professional, is completed as soon as possible. Fire risk assessments should be	Health and Care Standards 2015 - 2.1 Managing Risk and Promoting Health and Safety	All staff have had fire extinguisher training and are furthering their training on the mandatory training website. AT present 7 members of staff have completed online training and a further 6 members of staff will complete when they are back from annual leave and sickness. Certificates are attached. All the new fire extinguisher have bilingual notices and have been displayed in and around the surgery appropriately. All staff have been instructed to be more vigilant around	Kerry Hagland	Completed by 25 July 2017

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
kept up to date, monitored, with actions implemented to minimise risks within the environment on an ongoing basis.		the surgery, reception staff to make sure all visitors sign in reception visitors book and to turn off all non-essential electrical equipment which have already been PAT tested. Fire risk assessment company has been booked for 25th July 2017. The company who will complete the fire risk assessment will be CHUBB. The fire risk assessment will commence and this will include new fire emergency lights being fitted. Two members of staff will be trained as wardens, myself being one on 28th June 2017, this is recognised training with Fire Industry Association. I will then be able to bring back into the surgery the training and make more changes if necessary until all Risk Assessment work has been completed. New emergency lights are to be fitted by qualified member of staff of CHUBB. The fire alarms are already checked on a weekly basis by a member of		

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		trained staff and are monitored by a company called Dragon. We are planning w/c 5th June 2017 to commence a fire drill where the building will be evacuated, this will enable both staff and patients to recognise practice fire drill procedures. The evacuation has now taken place please find attached emergency evacuation report.		
Finding – Dealing with medical emergencies - Resuscitation equipment bag, emergency drugs and CPR training: We found significantly out of date stock in the resuscitation equipment bag including ambubags, airway adjuncts, needles, cannulae and manual suction device. We could not be assured that there was an appropriate system in place for obtaining medicines for use as emergency drugs.	Health and Care Standards 2015 - 2.1 Managing Risk and Promoting Health and Safety; 2.6 - Medicines Management; 2.9 - Medical	The resuscitation equipment has been updated. Prince Charles Hospital in Merthyr Tydfil - the resuscitation department. delivered a new resuscitation bag with up to date equipment. This is now kept in reception area. The staff CPR training is 14th September 2017 and has already been booked. This was the first date that the company had a vacancy to	Kerry Hagland Kerry Hagland	Completed Completed

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
We could not be assured that the current stock of emergency drugs would allow for safe practice in managing medical emergencies. The practice could not demonstrate that it had considered the appropriateness of all the drugs stocked nor the methods that would need to be used in administering them in an emergency. We also found one loose sheet of medication (without date). Staff had last completed CPR training in April 2016 and were due to complete this again in September 2017. Annual updates are recommended. This leaves a gap of five months between April – September 2017 when staff will not be up to date in terms of mandatory yearly updates. Improvement needed: The system for obtaining medicines to use as emergency drugs requires review to ensure it is appropriate.	Devices, Equipment, Diagnostic Systems; 7.1 - Workforce	fulfil all our staff training as we also had staff annual leave. The staff are completing online mandatory training until in-house surgery training is given. 7 members of staff have completed the online training so far and a further 6 members to complete when back from sickness and annual leave. Certificates are attached also. Emergency drugs list has been agreed by partners in practice and has been ordered both adults and paediatrics, these drugs are now in surgery. We are currently looking for a new Emergency Drug box. List of drugs will be kept in emergency box in reception as there is always available access to this box when needed with guidelines on the administration of the drugs. This box to be checked by practice nurse on a monthly basis and re-ordered when required.		

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
The contents of the emergency drugs box require full review to ensure it allows for safe practice in managing medical emergencies. The practice must take advice regarding the contents of the box to ensure there are appropriate medicines to manage adult and paediatric emergencies. Loose medication in the box must be removed. Out of date needles and cannula must be removed. The practice must ensure there is a system in place to check, monitor, review and replace (where needed) emergency equipment and emergency drugs stock on an ongoing basis. The practice must ensure that staff keep up to date with CPR training. Staff must assess the risks involved in the 5 months' gap in annual update training and ensure the team are sufficiently trained to handle medical emergencies through this time.				

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print): **MRS KERRY HAGLAND**

Job role: **PRACTICE MANAGER**

Date: **5 JUNE 2017**

Appendix C – Improvement plan

Service: Glyn Ebwy Surgery

Date of inspection: 16 May 2017

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The practice must ensure that patient confidentiality and privacy is protected at all times. Specifically, measures must be put in place to prevent conversations from being overheard in the waiting area when patients are being seen in the treatment/phlebotomists' room.	4.1 Dignified Care	The practice are looking at a license to play music in the waiting area near the treatment/phlebotomist rooms.	Mrs K Hagland	1 month
The practice must ensure that information is provided in a language and format that meets the needs of patients, including those patients who speak Welsh.	4.2 Patient Information	The practice will ensure that advertising in waiting room are in various languages and formats including Welsh. Will request advertisers to forward supply of	Mrs K Hagland	1 month

Improvement needed	Standard	Service action	Responsible officer	Timescale
		posters.		
The practice must review use of the tannoy system for calling patients into appointments to ensure there is a system in place that is accessible for all patients, including those with hearing difficulties. The practice must review the system for recording hospital discharge information on patient records and ensure that this is done consistently, and made clearly visible in all patient records on an ongoing basis.	3.2 Communicating effectively	The practice telecom supplier has been contacted and there is a site visit to review tannoy system and suggestions for a better calling system for patients especially those with hearing difficulties. The practice clinical system already records hospital discharges onto patient's records through DOCMAN. The practice will support staff in recording information from the hospital discharge more thoroughly.	Mrs K Hagland Mrs K Hagland	1 month 1 month
The practice must ensure there is a robust system in place to monitor and record referrals, ensuring that they have been received, particularly where these are urgent. Staff should consider auditing referrals with a view to reviewing current systems and improving practice where this may be possible.	5.1 Timely access	The practice already has a checking system in place to record and monitor all urgent referrals to ensure they have been received and acted upon. The practice secretary completes this check on a weekly basis. WCCGateway system already monitors referrals received.	Mrs K Hagland	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
Complaints information should be visibly displayed and easily accessible for patients.	6.3 Listening and Learning from feedback	The complaints information is already visibly displayed on the notice board by the entrance. It is displayed on A3 size.	Mrs K Hagland	Completed
Delivery of safe and effective care				
The practice should review access to the building to ensure that the difficulties experienced by patients using wheelchairs are resolved. There was a requirement for a formal programme of scheduled inspections and checks to be implemented for all fire equipment on an ongoing basis. The practice must take advice around this to ensure they comply with fire safety legislation. Staff must ensure that business continuity plans contain the most up to date information about how to manage risks.	2.1 Managing risk and promoting health and safety	There is already a buzzer at the front entrance of the surgery that patients using wheelchairs or patient that needs assistance can press. The buzzer will notify receptionists that they are needed at the front door. The Practice Manager and a full time staff member have received Fire Warden training with CHUBB. The practice has recently undertaken an evacuation of the building in a test. The practice is already booked for a Fire Risk Assessment and this will be repeated in correct legislation time. Fire alarms are regularly serviced and check on a weekly basis by a member of staff.	Mrs K Hagland Mrs K Hagland	Completed Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		All staff have been reminded of the fire safety legislation and are being vigilant. The practice business continuity plan has been updated for staff to be able to seek advice.	Mrs K Hagland	Completed
The infection control policy requires review to ensure it is complete. Staff should be trained in infection control and evidence of this should be recorded.	2.4 Infection Prevention and Control (IPC) and Decontamination	The infection control policy has been reviewed and staff are currently training in this online mandatory training.	Mrs K Hagland	Completed
Staff must ensure there is a system in place to remove medicines that are no longer needed from the repeat prescribing list. Staff must be aware of, and have knowledge of, the formulary to which they are working. The practice must confirm with HIW which formulary they are currently working with. Staff must report prescribing errors as significant events and must report adverse reactions to drugs.	2.6 Medicines Management	The practice repeat prescribing clerks are all competent in Level 1 prescribing and therefore are knowledgeable in ensuring medicines that are no longer needed are removed from the prescribing list. The practice is currently using ABUHB formulary. All repeat prescribing clerks have been reminded to report any errors and these will be reported as significant events and then these incidents will be discussed in practice meetings.	Mrs K Hagland	Completed.

Improvement needed	Standard	Service action	Responsible officer	Timescale
The practice must ensure that all staff receive up to date child protection and vulnerable adults training at a level appropriate to their role. This includes all staff, with clinicians now required to receive safeguarding training up to level three.	2.7 Safeguarding children and adults at risk	All staff are undertaking child protection and vulnerable adults training online. Clinicians/nurses are already booked onto a training course in-house to obtain Level 3 as required.	Mrs K Hagland	24th August 2017 to be completed.
The practice must ensure that they report all patient incidents and significant events appropriately. A culture of learning around incidents should be encouraged and promoted.	3.1 Safe and Clinically Effective care	All the incidents and significant events are reported to Practice Manager and Significant Events Proforma to be completed to enable all staff to discuss/learn from the events.	Mrs K Hagland	Completed
The consent policy must be updated to ensure it is up to date with the most recent legislation and case law, to govern working practices e.g. Montgomery judgement. The practice is required to demonstrate how improvements to record keeping will be made in the areas as identified in the report including: • Consistent linking of drugs prescribed to patient's condition.	3.5 Record keeping	Consent policy has been updated Clinicians will undertake regular checks on the summariser and read coding to ensure consistent coding is used. Clinicians will when patients are receiving medication reviews link drugs to patient's conditions.	Mrs K Hagland	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
• Consistent READ coding • Patient summaries require review to ensure consistency of quality • Recording when patients are provided with written information				
Quality of management and leadership				
The practice should ensure that duplicate/old policies are removed and current policies are easy to access, updated, and communicated to staff on an ongoing basis. The practice must consider how to share, encourage and promote learning, including peer review, and audit and improvement activities. There must be mechanisms in place to evidence that clinical discussions and learning takes place.	Governance, Leadership and Accountability	All staff Protocol and Policies folder have been updated and now containing updated information for access to all staff, the folder is located in reception. The practice has considered how to encourage and promote learning and peer reviews. Practice manager to take an active role in development activities and let staff know that the practice value these opportunities to further their careers. The practice is to show interest in the progress of each employee	Mrs K Hagland Mrs K Hagland	Completed Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		participating in online courses or special projects, and share their successes at staff meetings. Encourage employee enrolment in professional associations or organizations by their own participation. Help develop employees to perform a variety of roles this also makes good business sense, because it helps avoid hiring temporary staff to cover absences due to holidays or sick days. The practice will record all clinical discussions through practice meetings on a regular basis.		
All staff must receive annual appraisals. Relevant checks for all new members of staff must be recorded. The practice must ensure that staff are given sufficient support through the induction process. The locum GP pack must include comprehensive, useful information about the	7.1 Workforce	Only one practice nurse still needs to receive an annual appraisal. This has been difficult due to staffing issues and recruitment of new practice nurse. All relevant checks are completed and all are now recorded. All locums have a Locum GP pack this has now been updated to guide locum GPs.	Mrs K Hagland	To be completed by 7th July 2017

Improvement needed	Standard	Service action	Responsible officer	Timescale
practice to help guide locum GPs. Staff must ensure that mandatory training is completed in a timely way.		All staff have been reminded to ensure mandatory training is completed especially those staff who have returned from annual leave and have yet to complete resuscitation training.		

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): **MRS K A HAGLAND**

Job role: **Practice Manager**

Date: **4th July 2017**