Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection (Announced)

Llanyravon Surgery / Aneurin

Bevan University Health Board

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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 Llanyravon Surgery at Llanyravon Way, Cwmbran, Torfaen, NP44 8HW, within Aneurin Bevan University Health Board on the 20 March 2018.

Our team, for the inspection comprised of a HIW inspection manager (inspection lead), GP and practice manager peer reviewers and a lay reviewer.

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.

2. Summary of our inspection

We found evidence that the service made efforts to provide safe and effective care to patients. However, we found 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:

- Most patients told us they were satisfied with the level of service provided by the practice
- A range of information was available and the practice had an informative website
- Efforts were made to provide timely care for patients
- The practice had worked with a disabled patient to review the accessibility to the building and arrangements were described to improve access
- We identified effective leadership of non clinical staff
- Staff we spoke to demonstrated a commitment to developing their individual roles to promote the effective running of the practice.

This is what we recommend the service could improve:

- Aspects of record keeping, including; demonstrating valid patient consent has been obtained and recording when written advice has been provided to patients at consultations
- Aspects of medicines management
- The leadership of clinical staff and developing systems to clearly demonstrate activities that promote safe and effective care to patients.
- Aspects of staff recruitment checks.

3. What we found

Background of the service

Llanyravon Surgery currently provides services to approximately 4500 patients in the Pontrhydyrun, Pontnewydd, Croesyceiliog, Northville, Southville, Llanyravon, Oakfield and Llantarnam areas of Torfaen. 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 a GP, a nurse practitioner, a practice nurse, two healthcare support workers, a practice manager and a team of receptionists and administration staff. At the time of the inspection two locum GPs were also working regularly at the practice.

Other healthcare professionals who regularly visit and work from the practice include counsellors, midwives and district nurses.

The practice provides a range of services, including:

- General medical services
- Child/baby clinic
- COPD[1] clinic
- Diabetes clinic
- Cervical screening
- Contraception advice
- Minor injury service
- Phlebotomy

[1] Chronic obstructive pulmonary disease (COPD) is the name for a group of lung conditions that cause breathing difficulties.

- Travel vaccinations
- Non NHS services (for example completing insurance claim forms).

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.

Most patients who provided comments told us they were satisfied with the level service provided by the practice.

We saw staff treating patients in a kind and courteous manner and arrangements were in place to promote the privacy and dignity of patients.

Efforts were made to provide patients with sufficient information about the services offered by the practice and about their care. We did identify that improvement was needed around recording the information provided to patients during consultations.

Patients had opportunities to provide feedback about their experiences. At the time of our inspection the practice did not have a Patient Participation Group and efforts should be made to re-establish such a group.

Prior to the inspection, we invited the practice to distribute HIW questionnaires to patients to obtain views on the services provided. We also spoke to a number of patients attending the practice on the day of our inspection and invited them to complete a questionnaire. In total, we received 28 completed questionnaires, the majority of which were from long term patients at the practice (those that had been a patient for more than two years). Patient comments included the following:

"I find the service very good at the practice…"

"Since a Dr left the practice it has become increasingly more difficult to see a doctor when needed."

"Very happy with all staff."

"Good surgery - staff show understanding and do their best to meet patients' needs."

"No consistency. Poor appointment system."

Overall, comments received from patients indicated that they were satisfied with the service provided by the practice. When asked how the practice could improve, the comments we received generally indicated that the practice needed more GPs and that longer opening times would be beneficial.

Staying healthy

Written health promotion information together with information about support groups was readily available within the waiting area. Much of this was in the form of leaflets, which patients could take home to read and keep for future reference. Clinical staff also confirmed that written patient information sheets were printed out and provided to patients during their consultations. We found, however, that this was not consistently recorded within patients' medical records.

Advice and information about organisations and services specifically for carers were available at the practice and on the practice's website. The practice also had a Carers Champion, providing a point of contact for people with caring responsibilities. Those staff we spoke to, however, were unsure of who the Carers Champion was. Arrangements should be made to increase staff awareness in this regard.

The practice had recently introduced a self service blood pressure monitor for patients to use. This meant that patients could monitor or check their blood pressure prior to their appointment and share the results with the nurse or GP so that further investigations/treatment could be arranged as necessary.

Improvement needed

The practice is required to provide HIW with details of the action taken to increase staff awareness of the role of the identified Carers Champion.

Dignified care

The majority of patients who returned a completed questionnaire told us they had been treated with respect when visiting the practice. Throughout the inspection, we saw staff greeting patients in a welcoming manner and treating them with respect and kindness.

A screen separated the reception desk from the waiting area and this arrangement provided a degree of privacy when staff were speaking over the phone and handling paperwork. Low level music was being played in the waiting room which helped reduce the likelihood of conversations being overheard by people in the waiting area.

Arrangements were in place should patients wish to speak to practice staff in private and away from the reception desk and waiting area.

Consulting and treatment rooms were located away from the waiting area. This helped to reduce the likelihood of patients' consultations being overheard by other people in the waiting area. We saw the doors to these rooms were closed at all times when practice staff were seeing patients. This meant staff were taking appropriate steps to maintain patients' privacy and dignity. Curtains were also available in these rooms and could be used to provide a greater level of privacy to patients.

The practice had a written policy on the use of chaperones and senior staff confirmed that staff had attended relevant training. The use of chaperones aims to protect patients and healthcare staff when intimate examinations of patients are performed. There was information clearly displayed advising patients that they could request a chaperone to be present. Whilst a policy was in place, this would benefit from including further details around what is expected of staff whilst carrying out chaperone duties.

Improvement needed

The practice is required to provide HIW with details of the action taken to include further details within the chaperone policy around what is expected of staff whilst carrying out chaperone duties.

Patient information

The practice had produced a practice information booklet. This provided details of the area the practice served, the services offered at the practice, the staff team, the opening times, the arrangements for accessing out of hours (emergency) medical advice, useful telephone numbers, the procedure for obtaining repeat prescriptions and how the practice protected patient confidentiality. It also contained information about how patients could provide feedback.

The practice had an informative website which included a copy of the practice information booklet together with a range of additional information and links to other related websites.

An up to date policy setting out the arrangements for obtaining valid patient consent was available. We reviewed a sample of patients' medical records and saw evidence to indicate that verbal information had been given to patients about their condition, investigation and management options. We also saw that discussions had been recorded for those procedures requiring written consent from patients. Within the sample of records we reviewed, however, no formal consent form had been signed by the patient to demonstrate that valid consent had been obtained. Arrangements must, therefore, be made to address this.

Whilst clinical staff confirmed that written information is provided to patients during consultations, the sample of records we reviewed did not always demonstrate this. Arrangements should be made, therefore, to ensure that when written advice is provided to patients, this is recorded.

Improvement needed

The practice is required to provide HIW with details of the action taken to:

- ensure patients sign a consent form to demonstrate valid patient consent has been obtained as necessary
- ensure a record is made within patients' medical records when written advice is provided to patients.

Communicating effectively

The majority of patients who completed a questionnaire did not consider themselves to be a Welsh speaker or confirmed that they prefer to speak in English. All patients told us they were able to speak to practice staff in their preferred language. We were told that one of the GPs was a Welsh speaker. This meant that patients could communicate in Welsh if they wished to do so.

The practice had a self check-in (touch screen) machine that patients could use to confirm they had arrived for their appointment. This provided patients with a choice of languages they could use according to their language needs and preferences.

Information on the practice's website was available in a variety of languages.

The practice had a hearing loop system. This could be used to help communication between practice staff and those patients with hearing difficulties (and who wear hearing aids).

Some patient information leaflets were routinely available in both Welsh and English. Staff told us that not many of their patients requested to communicate in Welsh and this was reflected in the patient questionnaires that were returned. Given that the practice operates in Wales, however, the practice should consider providing more written information for patients in both Welsh and English.

The practice had systems in place for the management of external and internal communications. These involved a mixture of paper and electronic recording systems which created some unnecessary duplication. The practice may wish to explore how the functionality of the electronic system could be used further to reduce duplication, increase efficiency and provide a suitable audit trail.

Arrangements were described for ensuring that incoming correspondence/communication to the practice had been read and acted upon. Senior staff explained that practice staff would contact those patients who needed to return to the practice for further or repeat tests. Whilst patients would be contacted, there was no system to check that patients had received the test required. Senior staff felt that this would be the responsibility of the individual concerned.

We looked at a sample of five discharge summaries received from local hospitals. Our discussions with senior staff indicated that quality of discharge information could be improved. This is a matter for the health board to address with the relevant hospitals.

Improvement needed

The practice is required to provide HIW with details of the action taken to make information available in Welsh and other languages and formats to meet the communication needs of the population that it serves.

Timely care

Most patients who completed a questionnaire told us that they were very satisfied with the opening hours of the practice. Some patients told us that they were fairly satisfied and two patients were fairly dissatisfied.

The practice opened between 8:30am to 6:00pm Monday to Friday. A mixture of pre-bookable (routine) and on the day (emergency) appointments was offered. Patients were advised to telephone the practice to make an emergency appointment. Routine appointments could be made over the telephone, in person by visiting the practice or using My Health Online[2].

All emergency appointments were with the advanced nurse practitioner who could then refer patients to a GP if necessary and following an assessment.

The practice also participated in the Choose Pharmacy[3] initiative, where patients would be signposted, where deemed appropriate, to a local pharmacist for advice and treatment on a range of minor ailments.

The practice nurse ran a number of chronic disease management clinics where patients were monitored and given advice on managing their conditions.

The above arrangements aimed to reduce demand for appointments with GPs whilst ensuring that patients were seen by an appropriate healthcare professional depending on their care and treatment needs. This would allow more time for GPs to see those patients with more complex health conditions.

The practice offered home visits to patients who were too ill to attend the practice and those who were housebound.

Arrangements via the health board were in place to provide cover for urgent medical care out of hours. The majority of patients that completed a questionnaire told us that they knew how to access the out of hours GP service. Given that some patients did not know, however, the practice should make arrangements to further increase patients' awareness in this regard.

When asked to describe their overall experience of making an appointment, the majority of patients described their experience as very good or good. A few patients, however, described their experience as poor. The majority of patients

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[2] My Health Online is a web-based tool designed to enable patients to book appointments and order repeat prescriptions without having to attend the GP surgery.

[3] Choose Pharmacy supports the aims of the Welsh Government's national plan for primary care, using the skills and expertise of the wider primary care team, including pharmacists, so GPs have more time to focus on people with more complex health conditions.

that completed a questionnaire told us that they find it very easy or fairly easy to get an appointment when they needed one. A few patients, however, told us that they find it not very easy or not at all easy. The practice should explore whether any further improvements can be made in this regard given the comments we received from patients.

Whilst senior staff confirmed that in house second opinions were used, the process for this was informal. These aim to ensure that patients receive the most appropriate ongoing care from the most appropriate healthcare professional.

Referrals to secondary care (hospital) services were made via the Welsh Clinical Communications Gateway (WCCG)[4]. This provides an audit trail to show that referrals have been sent to, and have reached, the relevant hospital. We were informed that referrals were made in a timely manner; either completed on the same day, or within 48 hours after this had been agreed with the patient. Senior staff confirmed that a system was in place to check that urgent referrals, for example those for suspected cancer, had been received and acted upon by secondary care services.

Senior staff confirmed that there was no formal system for the peer review of the outcomes of patient referrals. This would be considered a useful element of a practice's governance arrangements. There was no peer review of individual GP patient referral patterns/rates, which is regarded as good practice within primary care.

Improvement needed

The practice is required to provide HIW with details of the action taken to implement and maintain:

- a formal system of in house second opinions
- a formal system of peer review of outcomes of patient referrals and GP patient referral patterns/rates.

[4] 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

Planning care to promote independence

The practice was located in a purpose built building and all consulting and treatment rooms were located on the ground floor. This arrangement together with level access to the building helped people with mobility difficulties enter and move around the practice safely.

Practice staff explained that patients' records could include a flag to identify those individuals with additional needs. This information would be added when the practice was informed of any changes or when patients first registered with the practice. This information would then alert practice staff so that suitable arrangements could be made as appropriate, for example, when arranging appointments.

As described earlier, a range of health promotion material was available both at the practice and on the practice's website. This aimed to help patients look after their own health and wellbeing.

There were arrangements in place to meet the needs of patients with additional health related conditions. Senior staff confirmed that regular health reviews of those patients with learning disabilities took place.

People's rights

Our findings that are described throughout this section (Quality of patient experience) indicate that the practice was aware of its responsibilities around people's rights.

For example, we saw that patients were treated with respect and efforts made to protect their privacy. We also found that efforts were made to provide services to patients, taking into account their individual needs.

Listening and learning from feedback

The majority of patients who completed a questionnaire said that they would know how to raise a concern or complaint about the services they receive at the practice.

The practice had a procedure in place for patients and their carers to raise concerns or complaints about the services they receive. The procedure was in keeping with the current arrangements for dealing with concerns (complaints) about NHS care and treatment in Wales, known as Putting Things Right. Information for patients was prominently displayed in the waiting area.

Reference to the complaints procedure was also made within the practice information leaflet and a copy of the procedure was available on the practice's website.

We reviewed a sample of the complaints reported to the practice during 2017. Copies of correspondence showed that these had been investigated and responded to within the timescales set out within Putting Things Right.

We saw that a suggestion box was available near the reception desk. This could be used by patients to provide ad hoc feedback about their experiences.

Senior staff confirmed that a Patient Participation Group (PPG) had previously been established but was no longer active. Such a group would provide a forum for patients to engage with the practice team and to provide feedback with a view to improving services.

Improvement needed

The practice is required to provide HIW with details of the action taken to re-establish a Patient Participation Group.

Delivery of safe and effective care

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

We found that patients were provided with safe and effective care.

We did identify that some improvement was needed to develop and formalise systems to clearly demonstrate the activity to promote safe and effective care to patients. These were in relation to peer review, aspects of medicines management and the implementation of new clinical guidelines.

Arrangements were in place for safeguarding children and adults who become vulnerable or at risk.

Overall, record keeping within patients' medical records was of a satisfactory standard. We did, however, identify some improvement was needed in this regard.

Safe care

Managing risk and promoting health and safety

As described earlier, there was level access to the front entrance of the practice. The reception desk, waiting area, consulting rooms, treatment rooms and patients' toilet were all located on one floor. This helped people with mobility difficulties and parents with pushchairs to enter the building and access the practice safely.

The majority of patients that completed a questionnaire felt that it was very or fairly easy to get into the building. Comments from two patients, however, indicated that they did not find it very easy. We were told that improvements to the front entrance were being considered to make access easier. Senior staff explained that the practice had worked with a disabled patient to review the accessibility to the building. We identified this as noteworthy practice and a good example of including patients when developing services.

During a tour of the building, we saw that areas used by staff and patients were clean, generally tidy and generally well maintained. The practice had conducted

a health and safety audit during December 2017. We did identify that the boiler room was being used to store some cleaning equipment and other items that may have posed a fire hazard. We informed senior staff of our findings and the items were removed before the end of our inspection.

Fire safety equipment was located around the practice. Labels on fire extinguishers indicated that these had been serviced within the last year to check it was working. Whilst, senior staff had completed a fire safety risk assessment in October 2017, they had identified that a more comprehensive assessment was required. An external company had already been arranged to conduct the assessment on the day after our inspection visit. Following our inspection, senior staff confirmed that the assessment had been completed as planned. Whilst some areas for improvement were identified, senior staff confirmed that no immediate action was required. HIW require an update, however, on the action taken as a result of the fire safety assessment.

Senior staff confirmed that contingency plan arrangements were in place should the practice not be able to operate out of the existing building, for example as a result of fire or other extreme event.

Improvement needed

The practice is required to provide HIW with details of the action taken / to be taken to address the requirements identified from the fire safety assessment conducted on 21 March 2018.

Infection prevention and control

There were no concerns expressed by patients over the cleanliness of the practice. Patients who completed a questionnaire felt that, in their opinion, the practice was either very clean or fairly clean. Most felt that the practice was very clean.

Hand washing and drying facilities were available in the toilets. Effective hand washing helps to reduce cross infection.

The treatment room and consulting rooms appeared visibly clean. Hand washing and drying facilities were also available in these rooms to help reduce cross infection. We saw that personal protective equipment (PPE) such as gloves and disposable aprons were available to clinical staff to reduce cross infection. Nursing staff confirmed that PPE was always readily available.

The treatment room had washable flooring to facilitate effective and easy cleaning. The other rooms were carpeted. The practice should consider

replacing carpets in these rooms, where frequent spillages are anticipated, to help promote effective infection prevention and control. This decision should be informed by a local risk assessment that takes into account the intended use of the rooms.

We saw that domestic (household) waste and clinical waste (including medical sharps) had been segregated into different coloured bags/containers to ensure it was disposed of safely and correctly. Clinical waste awaiting collection was securely stored to prevent unauthorised access.

Nursing staff had access to up to date local policies and procedures in relation to infection prevention and control. Training records showed that staff had completed training on infection prevention and control.

Senior staff confirmed that the Hepatitis B immunisation status of clinical staff was checked as part of the employment process. We saw that individual records had been kept. At the time of our inspection, the practice was experiencing difficulty in obtaining the Hepatitis B vaccine. This was attributed to a global shortage.

Medicines management

Senior staff confirmed that no specific practice formulary was used. Arrangements should be made to implement an agreed formulary. This would assist clinicians to prescribe medication from a preferred list of medicines taking into account local and national guidance.

Senior staff confirmed that there was no formal system to regularly review the prescribing system. A formal system would help to identify any issues with a view to making improvements that promote the safe and effective prescribing of medicines.

We saw that the reasons for prescribing medication were clearly recorded within the sample of patients' medical records we reviewed. Arrangements were described for removing medications from the repeat prescribing list when they were no longer required. The records we reviewed had limited details (on the deleted drugs screen) of the individual reasons why a patient may have stopped their medication. Recording this information would help clinicians during consultations to make decisions around the ongoing care and treatment of individual patients.

There were a number of ways by which patients could obtain their repeat prescriptions and these were described in the practice information leaflet.

There was no formal system in place to identify training required by team members relating to prescribing. Rather ad hoc opportunities were used to provide feedback.

A set of emergency equipment and drugs was available to respond to a patient emergency (collapse). We saw records demonstrating that staff had regularly checked the equipment and drugs to establish they were ready to use in the event of a patient emergency. Equipment and drugs were centrally located and easily accessible. Drugs were kept securely in a locked cupboard. We recommended that the key be stored in a location so that the drugs could still be accessed quickly but also to deter unauthorised access to the cupboard.

Senior staff had developed a training matrix and this showed staff had attended training on cardiopulmonary resuscitation (CPR). We recommended to senior staff that they refer to guidelines[5] issued by the Resuscitation Council (UK) to check that training for non clinical staff was being offered at a suitable frequency in accordance with best practice. This is important given that staff were performing dual roles, for example, administrative duties and phlebotomy.

Improvement needed

The practice is required to provide HIW with details of the action taken to:

- implement an agreed formulary
- regularly review the prescribing system
- ensure patients' medical records contain sufficient details around removing medication from the repeat prescribing list
- implement a formal system to identify training required by team members relating to prescribing.

[5] Resuscitation Council (UK) Quality standards for cardiopulmonary resuscitation practice and training. Primary Care - Quality standards https://www.resus.org.uk/quality-standards/primary-care-quality-standards-for-cpr/#training

Safeguarding children and adults at risk

Written procedures were available in relation to safeguarding children and safeguarding adults at risk.

Arrangements were described for recording and updating relevant child protection information on the electronic patient record system. Senior staff confirmed that the lead GP at the practice acted as a child and adult protection lead. This meant that staff had a local contact person to report, and discuss, concerns in relation to safeguarding issues. Not all staff we spoke to knew who the safeguarding lead for the practice was. Staff did confirm, however, that should they have concerns about patients, they would seek advice from senior staff. The practice must, however, make suitable arrangements to increase staff awareness of the safeguarding lead within the practice.

A training matrix had been developed and this showed that the majority of staff had completed (mandatory) safeguarding training. We were told that further training had been arranged to ensure that relevant staff attended training at a suitable level as set out in national guidance[6].

Improvement needed

The practice is required to provide HIW with details of the action taken to increase staff awareness of the role of the identified safeguarding lead.

Effective care

Safe and clinically effective care

Senior staff confirmed they discussed significant incidents and patient safety incidents. We were also told that staff involved would be invited to such meetings and that that learning was shared with all relevant staff as

[6] Safeguarding children and young people: roles and competences for health care staff. Intercollegiate Document, Third edition: March 2014 http://www.apagbi.org.uk/news/2014/safeguarding-intercollegiate-document-2014-released

appropriate. We were told that incidents were not routinely reported to the health board. Arrangements must be made to contact the health board to confirm the reporting criteria to ensure relevant incidents are reported as required.

Senior staff confirmed that relevant safety alerts were circulated to members of the practice team as appropriate.

We were told that clinical staff were responsible for keeping themselves up to date with best practice, national and professional guidance and on other topics relevant to their work. Arrangements were described for circulating relevant information and we were told that training would be provided as appropriate. There was no formal system in place for the clinical team to discuss new clinical guidelines, for example NICE guidance, and to agree how these may be implemented. Arrangements, therefore, need to be made to address this.

Arrangements were described for keeping non clinical staff up to date with best practice and on other topics relevant to their work. We were told that training would be offered to staff as appropriate.

Improvement needed

The practice is required to provide HIW with details of the action taken to:

- ensure that serious incidents are reported to the health board as appropriate and in accordance with local requirements
- ensure that new clinical guidelines are discussed and agree how these may be implemented within the practice.

Record keeping

We reviewed a sample of electronic patient medical records. These were secure against unauthorised access and easy to navigate. All the records we saw included sufficient details of the care/treatment given, together with the clinical findings. The records showed they had been completed in a timely manner.

We saw that all the records included key information, such as the identity of the clinician recording the notes, the date, and the outcome of, the consultation. We did identify that the electronic log-in details did not always correspond with the clinician making entries within the notes. We were told that this was due to difficulties in allocating individual log-in names to locum GPs, but they had been

instructed to record their identity within the notes for audit purposes. Senior staff confirmed that this issue had since been resolved.

We also found that it was not always clear where the consultation had taken place, i.e. at the surgery, over the telephone or at the patient's home (home visit).

We found that Read[7] codes were not used consistently by clinicians. Rather notes contained more free text and the choice of codes appeared to be based on each clinician's individual judgment rather than being based on an agreed list. A consistent approach would facilitate both continuity of the patient medical record and effective and accurate audit activity.

As described earlier, we identified improvement was needed in relation to the completion of written consent forms and to show when written advice is provided to patients.

The records we reviewed of patients that had significant and long term conditions included a summary. This included a summary of past and continuing problems, medication taken and allergies/adverse reactions. This helps the clinical team to make decisions about on-going care. Senior staff confirmed that non clinical staff completed summaries and that they had attended training in this regard.

Senior staff confirmed audits of patient medical records were routinely done. Given our findings however, the practice should review its approach to audit to ensure it is effective.

Improvement needed

The practice is required to provide HIW with details of the action taken to:

- ensure patients' medical records clearly reflect where consultations have taken place

[7] Read codes are a set of clinical computer generated codes designed for use in Primary Care to record the every day care of a patient. The codes also facilitate audit activity and reporting within primary care.

- promote the consistent use of Read coding
- ensure an effective audit system of patient medical records is in place.

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.

At the time of our inspection, the practice was owned and operated by one GP partner. A practice manager was in post and good working relationships between the management and the practice team were demonstrated.

Whilst, we identified effective leadership of non clinical staff, the leadership of clinical staff was less well developed.

Staff we spoke to demonstrated a commitment to developing their individual roles to promote the effective running of the practice.

We saw evidence to demonstrate that checks are performed as part of the recruitment process. We identified that some improvement was needed around the system for checking Disclosure and Barring Service (DBS) certificates via the DBS update service.

Governance, leadership and accountability

At the time of our inspection, the practice was owned and operated by one GP partner. A practice manager was in post and responsible for the day to day management of the practice. The practice was advertising for a second partner or salaried GP to support the existing management team. In the interim, two locum GPs were working regularly at the practice to ensure a suitable level of service to patients was maintained.

It was evident from discussions with senior staff that the practice had experienced challenges over the last year in recruiting and retaining clinical staff. Despite these challenges, the practice team remained committed to providing patients with a range of general medical services. Discussions with senior staff indicated that more support from the health board's Primary Care Operational Support Team (PCOST) may have been beneficial during this time.

A patient focussed approach was clearly demonstrated and members of the team that we spoke to were keen to develop their roles to facilitate the effective running of the practice.

We saw formal and effective systems in place for the leadership and management of non clinical staff.

We identified, however, that more formal systems needed to be implemented to provide (and demonstrate) effective leadership and to promote the development of the clinical team. This is reflected in our findings under section, Delivery of safe and effective care. In addition, conversations with senior staff confirmed that whilst meetings between clinical staff took place to discuss clinical cases, this was not formalised and was ad hoc. Similarly, whilst some peer review did take place, this was also informal and ad hoc. Peer review is considered a useful element of a practice's governance arrangements.

In addition, more formal arrangements needed to be introduced to demonstrate how business decisions are made and agreed by the management team. Senior staff confirmed that management meetings were informal and no written minutes were kept.

Staff we spoke to felt that communication within the practice was good. Staff confirmed that they felt able to raise any work related concerns with their manager. They also felt that their concerns would be dealt with fairly and appropriately. This demonstrates an open reporting culture that promotes staff and patient wellbeing.

During 2017, the practice had developed a three year practice development plan (PDP). This identified a number of actions and we saw that work was progressing on a number of these at the time of our inspection.

A range of up to date written policies and procedures was readily available to guide staff in their day to day jobs to promote safe and effective care. Staff we spoke to were aware of how to access the practice's policies.

The practice was part of a local GP cluster[8]. We were told that the GP partner and practice manager attended cluster meetings regularly. This helps promote cluster working and engagement. Senior staff felt that the cluster worked well together.

Improvement needed

The practice is required to provide HIW with details of the action taken to:

- provide effective leadership and to promote the development of the clinical team within the practice
- demonstrate how business decisions are made and agreed.

Staff and resources

Workforce

Staff we spoke to were able to describe their particular roles and responsibilities, which contributed to the overall operation of the practice.

Comments from staff indicated that they were supported to attend training relevant to their role. As mentioned earlier, staff showed a willingness to develop their roles for their own professional development and to facilitate the effective running of the practice. Senior staff explained that staff are trained to perform each others' roles so that they can provide cover when their colleagues are on leave.

Senior staff had recently developed a training matrix. This was useful to show, at a glance, the type of training and the date it was attended by staff and when updates were due.

Arrangements were described for staff appraisals and we saw an example of a completed appraisal within the sample of staff files we reviewed. Appraisals

[8] 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

help to identify training and development needs and provide an opportunity for managers to provide staff with feedback about their work.

We reviewed a sample of staff files. All staff had contracts of employment and job descriptions. We saw evidence to demonstrate that checks are performed as part of the recruitment process. This included checks to show that nurses were registered with their professional body and so entitled to practice. Whilst Disclosure and Barring Service (DBS) certificates were available we identified that update checks had not been conducted. This was attributed to a misunderstanding around the DBS update service[9]. Senior staff rectified this before the end of the inspection. HIW require, however, confirmation that such checks will be conducted routinely (as appropriate) as part of the recruitment process.

Improvement needed

The practice is required to provide HIW with details of the action taken to ensure that DBS checks for staff are valid.

[9] The DBS update service is an online subscription that allows persons to keep their standard or enhanced DBS certificate up to date and allows employers to check a certificate online.

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
We identified that equipment was being stored within the cupboard containing the gas boiler.	This may have posed a potential fire hazard.	We informed senior staff of our findings.	The equipment was removed from the cupboard immediately by practice staff.

Appendix B – Immediate improvement plan

Service: Llanyravon Surgery

Date of inspection: 20 March 2018

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
No immediate improvement plan required.	-	-	-	-

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):

Job role:

Date:

Appendix C – Improvement plan

Service: Llanyravon Surgery

Date of inspection: 20 March 2018

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 is required to provide HIW with details of the action taken to increase staff awareness of the role of the identified Carers Champion.	1.1 Health promotion, protection and improvement	The majority of staff already knew this but ALL staff have been reminded of who is the Carers Champion	Joanne Harris	Done
The practice is required to provide HIW with details of the action taken to include further details within the chaperone policy around what is expected of staff whilst carrying out chaperone duties.	4.1 Dignified Care	All staff have undertaken the training prior to the visit so they are aware of their roles Policy will be amended to include this	Jane Bedding	2 months
The practice is required to provide HIW with details of the action taken to: ensure patients sign a consent form to	4.2 Patient Information	We have done a form for patients to sign before any procedure is done at the practice, however we were trying to move away from paper and become	Jane Bedding	Done

Improvement needed	Standard	Service action	Responsible officer	Timescale
demonstrate valid patient consent has been obtained as necessary ensure a record is made within patients' medical records when written advice is provided to patients.		paper light in the Practice this is why we discarded the previous form and use verbal consent which is recorded on the patient's records		
The practice is required to provide HIW with details of the action taken to make information available in Welsh and other languages and formats to meet the communication needs of the population that it serves.	3.2 Communicating effectively	We do produce lots of information for patients in Welsh including our Practice Leaflet and Website, however we will endeavour to display more Welsh literature as and when it becomes available to us		Six Months
The practice is required to provide HIW with details of the action taken to implement and maintain: a formal system of in house second opinions a formal system of peer review of outcomes of patient referrals and GP patient referral patterns/rates.	5.1 Timely access	This is difficult for the Practice at the current time due to only having one Doctor however we are in the process of securing interviewing for a salaried GP and this will then be possible	Dr Alun Hughes	Six Months
The practice is required to provide HIW with	6.3 Listening and	The Practice has no intention to form a	Jane Bedding	N/A

Improvement needed	Standard	Service action	Responsible officer	Timescale
details of the action taken to re-establish a patient participation group	Learning from feedback	Group as the previous one disbanded due to lack of commitment		
Delivery of safe and effective care				
The practice is required to provide HIW with details of the action taken / to be taken to address the requirements identified from the fire safety assessment conducted on 21 March 2018.	2.1 Managing risk and promoting health and safety	Fire Assessment now carried out by Chubb – Recommendations to be carried out within 1 month: Replace one door on the 1st floor Carry out a 5 year test on electrics	Jane Bedding	Completed March 2018 Completed May 2018 Testing to be done In June 2018 booked
The practice is required to provide HIW with details of the action taken to: implement an agreed formulary regularly review the prescribing system ensure patients' medical records contain sufficient details around removing	2.6 Medicines Management	The Practice uses the formulary agreed by the Local Health Board for Medicines Management The Practice will introduce audits to be carried out quarterly	Local Health Board Jane Bedding	N/A June 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
medication from the repeat prescribing list implement a formal system to identify training required by team members relating to prescribing.		This is done every six months however the Practice will review this The Practice does have a staff training matrix which includes this for appropriate staff	Dr Alun Hughes Jane Bedding	June 2018
The practice is required to provide HIW with details of the action taken to increase staff awareness of the role of the identified safeguarding lead.	2.7 Safeguarding children and adults at risk	All staff have received written notification who this is although they have been informed and signed documentation in the past	Jane Bedding	Completed April 2018
The practice is required to provide HIW with details of the action taken to: ensure that serious incidents are reported to the health board as appropriate and in accordance with local requirements ensure that new clinical guidelines are discussed and agree how these may be implemented within the practice.	3.1 Safe and Clinically Effective care	Practice will look at reporting these via an alternative method other than Yellow Card Reporting – this is done alongside reporting of our Significant Events which are done on an annual basis in line with the Health Board directions The Practice has as arranged to carry out clinical meetings to discuss this	Clinical Staff Dr Alun Hughes	Six months July 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
The practice is required to provide HIW with details of the action taken to: ensure patients' medical records clearly reflect where consultations have taken place promote the consistent use of Read coding ensure an effective audit system of patient medical records is in place.	3.5 Record keeping	The Clinical Staff have started this process since it was suggested at the Inspection by the GP who attended Meetings arranged to discuss this and all staff have been provided with a list of regular codes	Dr Alun Hughes Jane Bedding	Started with immediate effect following visit June 2018
Quality of management and leadership				
The practice is required to provide HIW with details of the action taken to: provide effective leadership and to promote the development of the clinical team within the practice demonstrate how business decisions are made and agreed.	Governance, Leadership and Accountability	Clinical Meetings have been set up with Dr Hughes taking the lead for all clinical aspects Introduce more formal meetings between the GP and Practice Manager	Dr Alun Hughes Dr Alun Hughes	Commencing May 2018 June 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
The practice is required to provide HIW with details of the action taken to ensure that DBS checks for staff are valid.	7.1 Workforce	This has been in place within the Practice for many years however a policy will be introduced to carry out security checks in the interim pending DBS checks – unfortunately existing staff had DBS checks done previously not using the electronic system for checking however all new staff will have a DBS check.	Jane Bedding	July 2018 On going upon employing new staff

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): Jane Bedding

Job role: Practice Manager

Date: 26th April 2018