# General Practice Inspection (Announced)

## Pontprennau Medical Centre, Cardiff and Vale University Health Board

Inspection date: 5 November 2018

Publication date: 6 February 2019

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

**Communications Manager**

**Healthcare Inspectorate Wales**
**Welsh Government**

**Rhydycar Business Park**

**Merthyr Tydfil**

**CF48 1UZ**

Or via

**Phone:** **0300 062 8163**

**Email:** **hiw@gov.wales**

**Fax:** **0300 062 8387**
**Website:** **www.hiw.org.uk**

Digital ISBN 978-1-78964-770-9

# 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 Pontprennau Medical Centre at 33 Kenmare Mews, Cardiff, CF23 8RJ, within Cardiff and Vale University Health Board on the 5 November 2018.

Our team, for the inspection comprised of a HIW inspection manager (inspection lead), an additional inspection manager (shadowing the inspection), GP and practice manager peer reviewers and one 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

Overall, we found that Pontprennau Medical Centre provided safe and effective care to patients. However, we did find that the practice was not fully compliant with the Health and Care Standards in all areas of service provision.

This is what we found the service did well:

- Patients made positive comments about the service they had received from the practice
- We saw that staff were polite, courteous and professional to patients and visitors at the practice
- The practice was newly renovated and was visibly well maintained, clean, uncluttered, nicely decorated and well signposted internally
- Staff said that leadership within the practice was good and they were happy in their roles.

This is what we recommend the service could improve:

- Review and update written policies and procedures to ensure they all accurately reflect current arrangements at the practice
- Demonstrate that suitable staff recruitment checks have been conducted
- Ensure all staff have received up to date mandatory training and that records for this are kept within the practice
- Formalise practice meetings and utilise agendas, and develop meeting minutes to aid communication throughout the teams.

# 3. What we found

## Background of the service

Pontprennau Medical Centre currently provides services to approximately 10,000 patients in the Pontprennau and Pentwyn areas. The practice forms part of GP services provided within the area served by Cardiff & Vale University Health Board.

The practice employs a staff team which includes five GP partners (who own the practice), three practice nurses, one health care support worker, a practice manager and a team of administrative staff. The practice also provides training for GPs and has three dedicated GPs that provide training. There are currently three trainees within the practice.

There were also other clinical support services available that were provided by professionals employed by Cardiff and Vale University Health Board. These included district nurses, health visitors, midwives, a pharmacist and a smoking cessation counsellor.

The practice provides a range of services, including:

- General medical services
- Minor surgery
- Baby & child clinic and young person clinic[1]
- Blood pressure and heart disease risk assessment
- Asthma clinic & Diabetic clinics
- Family planning & Smear tests

[1] Young person clinic - In response to the health needs of the area, the Practice Nurse is happy to see young people to discuss health concerns, including sexual health issues in complete confidentiality (at the clinical discretion of the nurse).

- Travel advice and immunisation
- Dressings & removal of stitches
- Ear syringing
- Phlebotomy (taking blood for laboratory tests)
- Non NHS services (for example completing insurance claim forms).

For ease of reading, Pontprennau Medical Centre will be referred to as the practice throughout this report.

## 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.*

Patients provided positive comments about the staff team and the services provided at the practice. We saw that efforts were made to protect patients' privacy and dignity and that the services offered by the practice were accessible to patients. However, consideration is required to enable easier access for those with mobility difficulties to enter the external practice doors.

Prior to the inspection, we invited the practice to distribute HIW questionnaires to patients to obtain their views on the services provided. On the day of the inspection we also spoke to patients to find out about their experiences at the practice. In total, we received 41 completed questionnaires. The majority of the patients that completed a questionnaire were long term patients at the practice (that is, those that had been a patient for more than two years).

Patients were asked in the HIW questionnaire to rate the service provided by this GP practice. Responses were positive, and the majority of patients rated the service as either excellent or very good. Patient comments included the following:

> *"The service I have had and my family has been exceptional"*
>
> *"I would like to take this opportunity to thank all the doctors, nurses and support staff for the excellent care they have provided for me and my family over the past 15 years. I am very grateful to them all"*
>
> *"Very good and quick"*

### Staying healthy

There was some written information available within the practice to help patients and their carers to take responsibility for their own health and well-being. However, this was in a glass display case opposite the reception desk

and was out of sight of the main seated waiting area. A much broader range of information was displayed on two large visual display monitors in the main waiting area. There was also a visual display monitor within the first floor waiting area that replicated that of the ones in the main waiting area.

The monitors were a good information resource on health promotion amongst others, and the information displayed could be changed centrally to display any current public health issues or other health campaigns. However, for those who were visually impaired, the screens may not be of use and this was due to their distance from the seating areas. In addition, there were no leaflets available to support any of the information displayed within the glass display cabinet or the monitors, for patient to read at their seat, or to take away.

Advice and information specifically for carers, was displayed within the designated noticeboard in the waiting room. This was also displayed on the monitors. The practice also had a nominated carer's champion. We were provided with a brief description of this role, and this involved providing carers with useful information about various local agencies and organisations that may be able to support them with their day to day responsibilities.

The practice offered a range of general medical services that aimed to promote patients' health and well-being. These included providing guidance on fitness to work, advice on long term medical conditions such as asthma and diabetes, travel advice, smoking cessation, and particular medications such as warfarin[2].

The practice had a good Practice Development Plan (PDP) in place but it was completed over two years ago. Although practices are only required to update their PDP every three years, it would be advisable that they review their PDP to aid planning for the next year and in line with the recent completion of refurbishments. In addition, with their request to close their sister practice in Pentwyn that was declined by the local health board.

[2] Warfarin is a medicine that prevents blood clotting. Warfarin is often prescribed for people who have a mechanical heart valve replacement, specific irregular heart rates or have a condition caused by a blood clot such as a pulmonary embolism (a blood clot in the lungs). People taking warfarin need to have regular blood tests to ensure the dose they are taking is correct.

Improvement needed

The practice is required to provide HIW with details of the action it will take to ensure that:

- All patients have equal access to relevant health promotion information within the practice
- There is a supply of health promotion advice leaflets for patients to read and take away.

## Dignified care

All patients that completed and returned a HIW questionnaire felt that they had been treated with respect when visiting the practice. We also observed staff treating patients with courtesy and respect. However, just over a half of patients that completed a questionnaire told us that they could only sometimes get to see their preferred doctor.

Consulting rooms and treatment rooms were located on the ground and first floor and were away from the waiting areas. We saw that doors to the rooms were closed during consultations. This helped protect patients' privacy and dignity when they were reviewed by the GP or nurse. In addition, if a patient was required to provide a urine or stool sample, there was a designated toilet room available specifically for this away from the main toilets in the reception area.

Practice staff confirmed that patients could have a chaperone present during their consultations. The use of chaperones aims to protect patients and healthcare staff when intimate examinations of patients are performed. We were also told that it was expected that the GPs would offer chaperones in all appropriate circumstances.

There was chaperone information displayed within the main waiting area display cabinet and also on the monitors, advising patients that they could request a chaperone to be present. However, with the visually impaired (as discussed earlier), they may not be aware of this. Therefore, patients would benefit if this was also advertised closer to the seating area in the form of posters. This notice should also be available inside the consultation and treatment rooms.

Improvement needed

The practice is required to provide HIW with details of the action it will take to ensure that:

- All patients are aware of the availability of a chaperone prior to receiving consultation or treatment, within the waiting area and relevant rooms
- Information for the provision of a chaperone is clearly displayed for all patients within the waiting area and consulting/ treatment rooms.

## Patient information

The practice had a very informative website, which was easy to navigate with all the relevant information about services provided by the practice. In addition, information regarding the staff working there and other healthcare related information was also available. Furthermore, the pages could be translated in over 100 languages, which is an excellent initiative. The website also promoted My Health Online. This can assist patients to make appointments and request repeat prescriptions, both of which can be of benefit to patients and the practice.

The practice had produced an information leaflet for patients. This contained relevant information about the practice and the services offered. The leaflet also made reference to the data protection act and the security of patient data. However, whilst the leaflet made reference to operating a complaints procedure as part of the NHS system, this should be updated to provide clear and accurate reference to the NHS Wales Putting Things Right[3] process.

Within the practice, information for patients on how to raise a concern was not clearly displayed for patients. There was only one A4 size poster available

[3] 'Putting Things Right' is the integrated process for the raising, investigation of and learning from concerns. Concerns are issues identified from patient safety incidents, complaints and, in respect of Welsh NHS bodies, claims about services provided by a Responsible body in Wales.

regarding the NHS Wales Putting Things Right process, and this was within the glass display cabinet. This was not sufficient to inform all patients of the process. In addition, there were no Putting Things Right leaflets readily available for patients to read and take away. We were told that if a patient wanted a leaflet, they could ask at the reception. This was not ideal since many patients may not know that the process or leaflets exist.

We reviewed the medical records of a sample of patients. These clearly showed that verbal information had been given to patients to help them understand their medical conditions, associated investigations and management of their illness or condition. We also saw that there were suitable arrangements in place to obtain patient consent.

There was a policy in place for obtaining consent however, this requires review and updating, and with dates and version control applied to the policy. This would ensure that they have the most up to date version in place, and are reviewed appropriately. Reviews of all policies as described above has been addressed later within the report.

Improvement needed

The practice is required to provide HIW with details of the action it will take to ensure that:

- The patient information leaflet is updated to include relevant reference to the NHS Wales Putting Things Right process
- All patients are aware of the Putting Things Right process by displaying this appropriately within the practice
- That Putting Things Right information leaflets are readily available for patients to read and take away.

## Communicating effectively

All but two patients that completed a HIW questionnaire told us that they were always able to speak to staff in their preferred language. The majority of patients that completed a questionnaire felt that things were always explained to them during their appointment in a way that they could understand. Patients

also told us that they were involved as much as they wanted to be, in decisions made about their care.

The practice staff that we spoke to confirmed that a working hearing loop was available. This is used to help patients who have hearing difficulties, to communicate with staff. The staff also confirmed that they could access a translation service to help communication with patients who did not speak English, to understand what was being said during their consultations with the GP or nurse and vice versa. We were also told that patients were encouraged to bring someone with them if there were occasions where language barriers were expected or if it was difficult to access the translation service.

All areas of the practice were well signposted on the walls, to clearly orientate patients to the rooms and other facilities. The signs were also bilingual (in Welsh and English). In addition, we were told that the practice was also installing additional bilingual signs that would be suspended from the ceiling, the week following our inspection, as part of the practice refurbishment. This was to ensure that patients could follow the signs easier as opposed to just signs on the walls.

We were informed of the arrangements for ensuring that incoming correspondence or communication to the practice had been read and acted upon. If the matters required urgent attention, we were told that the administrative staff would write on post-it notes, and attach these to the GP's notes and prescriptions that they would complete, when they were out of their consultation rooms. There was a risk with this method, of failure in communication, whereby the notes could become unattached, or that there was no robust process in place to ensure that the GP had read or acted upon this information.

We also considered the arrangements in place for when patients required contact from the practice for additional requirements. For example, to return for a follow up appointment, a blood test, or to receive treatment/ prescription, based on test results. We were told that the practice staff would either telephone the patient/carer or write to them informing them for example, to book an appointment or collect a prescription. Once staff had done this, then they would consider that initial patient follow up as, case closed. However, this meant that there was no additional follow-up process in place to ensure that the patient had then attended an appointment or collected their prescription to commence necessary treatment. This potentially poses a risk to patient safety and maintaining well-being, if the process was not complete.

Through discussion with some staff, they felt that once they had informed the patient of what they were required to do, then it was the patients' responsibility to follow this through and make the necessary arrangements. We raised our concerns regarding this during the inspection, to the practice manager. She verbally assured that she would review this process to ensure a more robust one was put in place as soon as possible.

We looked at a sample of patient discharge summaries received from local hospitals. In addition, our discussions with senior staff indicated that the quality of some 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 it will take to ensure that:

- The process of informing doctors of matters that required urgent attention using post-it notes is reviewed, to ensure robust communication and to ensure appropriate action has been taken in relation to patient's care and treatment
- A robust additional follow up process is implemented and is auditable, to ensure that where applicable, patients have attended a follow up appointment or collected their prescription to commence necessary treatment
- The documentation and information provided within hospital discharge summaries to GP's, is reviewed to maintain robust communication, is addressed with the local Health Board.

## Timely care

The practice opens its doors to patients between 8:30am to 5:30pm Monday to Friday. However, it does not provide appointments between 12:30pm and 2:30pm although, the phone lines and doors remain open. A mixture of pre-bookable (routine) and on the day (urgent) appointments was offered. Patients are required to telephone the surgery from 8:00am onwards to secure an on the day appointment, since the practice does not open the doors until 08:30. Afternoon surgery was by appointment only with times ranging from 2.30-

5.20pm. On Wednesday and Friday afternoon, appointments are reserved for medical emergencies & runs from 3.45-5.30pm.

The Health Board does not commence its out of hours GP service until 6.30pm therefore, there is a one hour period where patients cannot physically access a GP at the practice or through the out of hour's service. Information was not clear, as to the process of access/ communicate to a GP for patients between 5.30pm and 6.30pm. This meant that there was a risk that in an urgent situation, patients may present to the surgery in person when the doors are locked, instead of calling the surgery telephone number for telephone advice.

The majority of patients that completed a questionnaire told us, that they were very satisfied or fairly satisfied with the hours that the practice was open. However, almost a quarter of the patients said, that it was not very easy or not easy at all, to get an appointment when they needed one.

Patients were asked in the HIW questionnaires how the practice could improve the service it provides. A number of patients raised some common concerns in relation to receiving timely care. These were notably around the difficulty in making an appointment and the lack of parking spaces at the practice. Patient comments included:

> *"More appointments available at short notice. I have had to wait one month to have a booked appointment"*
>
> *"More available booking appointments (emergency are easy to get but booking ones in advance is less available)"*
>
> *"The service is getting worse and restricted especially car park, apart from appointment with GP we can't park in car park for any other visit to surgery. For this reason it happened that I had to go back home as there was no parking available outside, while the surgery's car park was half full"*

The practice nurses run a number of chronic disease management clinics where patients were monitored and given advice on managing their conditions. This service aimed to reduce demand for appointments with GPs whilst ensuring that patients were seen by an appropriate healthcare professional. This would allow more time for GPs to see those patients with more complex health conditions.

We saw that the practice had a system in place when they received telephone enquiries for appointments. The GPs and pharmacist developed a flow chart to

assist the admin staff answering calls to direct the patient to the most appropriate practitioner or health care service, such as the nurse, GP, pharmacist, or directly to hospital. This was a good initiative to prevent booking patients in to unnecessary GP appointments, thus allowing more appointments for those who appropriately need them.

This system was devised to assist the admin staff to allocate the appointment to the most relevant practitioner. The practice offered home visits to patients who were too ill to attend the practice and those who were housebound. They also completed weekly ward visits to the designated Ty Enfys care home.

Arrangements via the health board were in place to provide cover for urgent medical care out of hours. However, around a third of the patients that completed a questionnaire told us that they would not know how to access the out of hours GP service.

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

We were informed that non urgent referrals were made within 72 hours after this had been agreed with the patient. Urgent referrals were completed sooner for example, the practice used urgent suspected cancer protocols to ensure that patients received care and treatment in a timely way. All such referrals were sent via all the All Wales electronic transfer arrangements. Practice staff confirmed that a system was in place to check that referrals had been received and acted upon by secondary care (hospital) services.

We were informed that the practice had a phlebotomy service which was undertaken by the practice health care assistant. If she was unavailable, the practice nurse, or doctors would obtain patients' blood samples if urgent, to ensure timely care.

### Improvement needed

The practice is required to provide HIW with details of the action it will take to ensure that:

- The availability of appointments on the day and booking in advance is reviewed

- All patients are aware of how to access the out of hours GP service
- The provision of telephone access only to a GP service between the hours of 5.30pm and 6.30pm is clearly communicated to the surgery's patients because the health boards' out of hour's service does not commence until 6.30pm.

## Individual care

### Planning care to promote independence

Patient facilities were located on both the ground and first floors of the practice. On entry to the practice, there were heavy frosted glass doors that had to be opened manually. There were no current plans to install any form of automatic doors as part of the recent redevelopment project.

A small number of patients that completed a questionnaire felt that it was not very easy or not at all easy to get into the practice building.

We identified that since the entrance doors were frosted and relatively heavy to open, there is a risk that frail patients or wheelchair users attending the practice alone, may not be able to open the door themselves. In addition, staff within the practice would not be able to see the patients through the frosted glass to know they were attempting to enter and furthermore, the reception staff were not facing the entrance doors.

We discussed the above potential issues with senior staff members who informed us that if they had a known patient attending the practice with mobility issues, then they would know the potential arrival time for them and could open the doors for them. However, when asked if someone arrived without an appointment, they said that they would have to knock on the door to enter. Senior staff told us that they would discuss this accessibility issue with the health board to explore the options of assistance to install automatic doors, for the benefit of patients and visitors to the practice.

The main reception desk had a low level section which would enable a wheelchair user to easily speak with reception staff. The doorways inside the building were wide enough to allow safe use of wheelchairs, motorised scooters and pushchairs. However, as the doors were all newly installed fire safety doors, they were heavy and quite difficult for some patients to open. There was also a lift installed to allow easy access to all patients to the first floor.

Car parking spaces were available for patients through an electronically operated barrier (to the rear of the practice) however, spaces were very few (approximately ten). Therefore, there were not enough spaces to allow for all patients attending the practice to park. There were also additional spaces through to the rear of the patient car park (of similar amount), designated for staff to park within. To the front of the practice, there were double yellow lines on both sides of the road, so patients could not park there. In addition, there was also very little parking available in the nearby residential area. This was reflected in many of the patient questionnaires, as highlighted earlier in the report, and when discussing with patients on the day of inspection.

There was a gender neutral toilet facility situated within the ground floor of the practice and a baby changing room. There was also a designated disabled toilet. This promoted the independence of patients with mobility issues. There were also patient toilets available on the first floor, but were not suitable for wheelchair users.

We found that the long term needs of some patients were monitored effectively. This was particularly the case for those patients with diabetes, asthma or high blood pressure.

We reviewed the registration form in use for new patients. Whilst the form would capture issues with patient reading and writing or other communication issues, there is a requirement to include other impairments such as mobility and disability issues and access these patients may need to and through the practice. This would alert the practice team prior to the patient arrival.

Improvement needed

The practice is required to provide HIW with details of the action it will take to ensure that:

- Access through the entrance doors is reviewed to ensure all patients can enter safely and independently
- Fair consideration is made in relation to parking for patients at the practice, particularly for those with mobility issues
- Review of the patient registration form is required, to ensure all impairments are captured such as, mobility issues.

## People's rights

We found that peoples' rights were promoted within the practice, and arrangements were in place to protect peoples' rights to privacy and saw staff treating patients with dignity, respect and kindness.

We also found that patients could be accompanied by their relatives or carers within the practice and during consultation or treatment if desired. Practice staff also confirmed that patients could have a chaperone present during their consultations.

## Listening and learning from feedback

Within the main reception area, there was a locked box to collect notes where patients could provide verbal comments and suggestions. However, the practice did not have readily available, any pens of paper for patients to document their comments. We were told by staff, that patients could ask for pen and paper at reception for this purpose. It may be of benefit to advertise to patients that they could ask at reception for these provisions.

There was no current system in place for recording verbal concerns/complaints, but formal or written complaints were recorded. In addition, response times, to concerns raised by patients, were not compliant with the NHS Wales Putting Things Right process. There was minimal information available for patients on the Putting Things Right, as highlighted earlier.

### Improvement needed

The practice is required to provide HIW with details of the action it will take to ensure that:

- It will develop a system for the recording and response to verbal concerns or complaints received from patients or relatives/carers, in-keeping with the Putting Things Right process.

## 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 that the practice had arrangements in place for the delivery of safe and effective care to patients. Notes made within patients' electronic medical records were clear and concise. However, we did identify some improvements required.

The improvements were in relation to the notes made in relation to medication, follow-up of patients for further appointments or treatments, significant incidents and sharing of patient safety alerts.

Further consideration with information governance is also required within the reception area and office to the rear of reception, to maintain patient confidentiality.

### Safe care

#### Managing risk and promoting health and safety

The practice had recently undergone a full refurbishment on both floors. The entire premises were found to be visibly clean, bright, well-organised and well-signposted. In addition, all treatment rooms were designed to ensure effective cleaning. There were no obvious environmental risks to patient or staff safety identified. As part of the refurbishment, the practice had purchased some bariatric[4] examination couches for use with very large patients.

There was sufficient seating for patients and their families if both waiting areas were in use. However, on the day of inspection we saw that eight people had to

[4] Bariatrics is the branch of medicine that deals with the causes, prevention, and treatment of obesity

stand within the main reception on the ground floor. This was because the practice had not yet opened the first floor rooms for consultations.

Senior staff confirmed that there was capacity within the practice team to cover their colleagues' roles. This provided some contingency to ensure that services were maintained in the event of long term staff absence.

Senior staff stated that there were arrangements in place with their nearby branch practice (St David's Medical Centre in Pentwyn), should the practice not be able to operate out of the existing building. For example, this occurred when the Pontprennau medical centre was being refurbished. The GPs and admin staff would work between both practices.

The practice had a business continuity plan in place however, this required updating.

We found that not all of the practice team who used computer equipment for many hours each day, had completed Display Screen Equipment (DSE)[5] training or completed individualised risk assessments. This was discussed with senior members of the team as such risk assessments are required under health and safety legislation.

Due to the recent renovation, the practice had recently had an external organisation to visit the practice to check fire safety equipment, and that fire safety risk assessments and policies were in place. All equipment had recently been tested for electrical safety.

[5] Employers are required to protect workers from the health risks of working with display screen equipment (DSE), such as PCs, laptops, tablets and smartphones. The Health and Safety (Display Screen Equipment) Regulations 1992 apply to workers who use DSE daily, for an hour or more at a time.

Improvement needed

The practice is required to provide HIW with details of the action it will take to ensure that:

- The business continuity plan is updated
- All staff where applicable complete a risk assessment and are trained for the use of display screen equipment.

## Infection prevention and control

There were no concerns raised by patients over the cleanliness of the practice, and all of the patients that completed a questionnaire felt that the premises was very clean.

Hand washing and drying facilities were available in key areas of the practice. In addition there were hand sanitising foam dispensers readily available. Effective hand hygiene helps to reduce the risk of cross infection.

The waiting areas, corridors, treatment rooms and consulting rooms all appeared visibly clean. We saw that personal protective equipment (PPE) such as gloves and disposable aprons were available for use by clinical staff to reduce the risk of cross infection. Nursing staff confirmed that PPE was always readily available.

Each of the treatment and consulting rooms had washable flooring, worktops and cabinets to facilitate effective and easy cleaning. The flooring was also washable throughout the waiting areas and corridors.

We saw that domestic (household) waste and clinical waste (including medical sharps for example, needles) had been segregated into different and appropriate 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 also confirmed that only sterile single use instruments were used when performing minor surgery procedures. The use of these helps prevent cross infection.

Nursing staff had access to a policy in relation to infection prevention and control. This was in need of reviewing so that it accurately reflected the current arrangements in relation to infection control audit activity and cleaning schedules. Whilst the policy referred to relevant procedures in relation to

inflection prevention and control, further details and guidance for staff on such procedures could have been included.

We saw evidence that individual records had been kept for all staff in relation to their Hepatitis B immunisation status.

All consulting and treatment rooms were fitted fabric dignity curtains around the examination couches. There were no current plans to use disposable curtains to help prevention or reduce the risk of cross infection.

We did not see evidence that an infection control audit had taken place.

Improvement needed

The practice is required to provide HIW with details of the action it will take to ensure that:

- The infection control policy is reviewed and for it to include reference to relevant procedures.

## Medicines management

The practice used the local health board formulary (and cross checked where required with the British National Formulary[6]), to refer to specific medications, and arrangements were in place to ensure that the most up to date information is used in accordance with local and national guidance. This meant that GPs prescribed medication from a preferred list of approved medicines.

[6] The British National Formulary is a United Kingdom pharmaceutical reference book that contains a wide spectrum of information and advice on prescribing and pharmacology, along with specific facts and details about many medicines available on the UK National Health Service. Information within the BNF includes indication(s), contraindications, side effects, doses, legal classification, names and prices of available proprietary and generic formulations, and any other notable points.

A pharmacist visited the practice weekly. This was via arrangements with the GP cluster[7] that the practice was part of. The pharmacist would review regular medications of patients and liaise as appropriate with the GPs, if any amendments were required. Senior staff confirmed that annual reviews of patients' repeat medication were undertaken. Where it was identified that patients were no longer taking medicines, we were told these medicines were removed from the repeat prescribing list.

Within the sample of patients' medical records we reviewed, we saw the reasons for prescribing medication had been recorded. Recording this information helps inform decision making when reviewing treatment at future consultations. Whilst this information was recorded, we saw an inconsistent and variable approach to the documentation. Using an agreed approach may help GPs find this information more easily. In addition, the records we reviewed did not always include the reasons why a patient may have stopped their medication. Similarly, recording such reasons would help to inform future consultations.

The practice had equipment and drugs available for use in the event of a patient emergency (collapse) at the practice. We saw records had been kept that showed the equipment and drugs had been checked monthly. This was to check that they are always available and ready to use. A system for obtaining replacement equipment and drugs was described. Whilst checks had been completed monthly, the practice should consider increasing the frequency of such checks to weekly as recommended by guidance[8] produced by the Resuscitation Council (UK).

Training records showed that staff had undertaken resuscitation training. However, this training was out of date for a number of staff, with some showing last training dates of 18 to 24 months.

---

[7] A Cluster is a grouping of GPs working with other health and care professionals to plan and provide services locally. Clusters are determined by individual NHS Wales Local Health Boards (LHB's). GPs in the Clusters play a key role in supporting the ongoing work of a Locality Network.

[8] Resuscitation Council (UK) - Quality Standards for cardiopulmonary resuscitation practice and training

Improvement needed

The practice is required to provide HIW with details of the action it will take to ensure that:

- A consistent approach by clinicians is promoted with recording reasons for prescribing or discontinuing medication within patients' medical records
- Emergency equipment is checked and recorded weekly
- Ensure all practice staff complete annual resuscitation training.

## Safeguarding children and adults at risk

A policy and other forms of written procedures in relation to safeguarding children and adults at risk were available within the practice. Such procedures aim to promote and protect the welfare and safety of children and adults who are vulnerable or at risk.

Arrangements were described for recording and updating relevant child protection information on the electronic patient record system. Senior staff confirmed that a designated GP at the practice was a lead for child and adult protection/ safeguarding. This meant that staff had a local contact person to report, and discuss, concerns in relation to safeguarding issues.

The designated safeguarding lead also provided in-house safeguarding training to staff within the practice. However, we did not see evidence that every staff member had undertaken any safeguarding training. In addition, this training was informal. All registered clinical staff had received formal level three safeguarding training.

We were told that the GP lead for safeguarding undertakes regular searches of the child protection register and reports this to the practice manager to ensure alerts are placed or removed within the electronic patient system where applicable. Health visitors were also attached to the practice and arrangements for multi-professional working were described to promote the welfare and safety of children.

Staff we spoke to confirmed that should they have any concerns around a patient's welfare, they would report this to senior practice staff.

The practice was unable to provide us with evidence to the appropriate level for all staff for Disclosure and Barring Service (DBS)[9] checks, as part of its recruitment arrangements. We refer to the issue of recruitment further in the next section of this report titled Quality of Management and Leadership.

Improvement needed

The practice is required to provide HIW with details of the action it will take to ensure that:

- Every member of staff has undertaken safeguarding training for children and adults and that all staff receive regular training updates.

### Medical devices, equipment and diagnostic systems

All medical devices, equipment and any diagnostic systems were in a good state of repair, well maintained and fit for purpose and where appropriate, had been electronically safe tested.

## Effective care

### Safe and clinically effective care

Senior staff confirmed that patient safety incidents were reported directly via an electronic reporting system for inclusion on a national database (National Reporting and Learning System[10]) to promote patient safety.

[9] DBS checks identify whether a person has a criminal record, or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

[10] The National Reporting and Learning System (NRLS) is a central database of patient safety incident reports

We were told that any significant patient safety incidents were discussed during weekly clinical meetings and then shared with the wider team during practice meetings. This was with the aim of sharing relevant information and identifying any learning and to prevent reoccurrence.

We identified that the GPs had a good knowledge of current guidelines produced by the National Institute for Health and Care Excellence (NICE)[11]. However, there was no evidence of formal discussion of those guidelines with other relevant members of the team.

Senior staff confirmed that relevant safety alerts were circulated ad hoc throughout the practice team as necessary and usually at the monthly team meetings. Arrangements were also described for discussing and keeping staff up to date with best practice and professional guidance.

There were minimal meeting minutes available (to support that discussed above), for staff to read; particularly for those not in attendance. It is advisable that the practice records all meeting minutes and shares with all practice staff, if they were present at the meetings or not. This is to maintain effective communication and shared learning to promote patient safety.

Improvement needed

The practice is required to provide HIW with details of the action it will take to ensure that:

- Significant events and new guidelines are always shared with staff in a formal and timely manner.

### Information governance and communications technology

The reception desk was located in the main waiting room. This could present challenges with maintaining robust privacy and data protection of patients,

[11] The role of the National Institute for Health and Care Excellence is to provide patients, health professionals and the public with authoritative, robust and reliable guidance on current 'best practice'.

when staff needed to talk to patients attending the practice, with personal or sensitive information. However, the practice had considered patient privacy and data protection during the refurbishment. There was a small private room available immediately to the side of the reception desk to undertake any private conversations. In addition, we were told that if requested, nursing mothers could use this room to breastfeed.

Telephone calls made to or from the practice were undertaken in an office immediately behind the reception area. This did pose a risk of patients stood at the reception desk or in some waiting area seats, overhearing some conversations. This was because there was no door separating the reception and office. However, we were verbally assured that the practice was already addressing this issue and are awaiting full length glass doors to be installed between the two areas.

The reception area had a lowered section immediately next to the check in screen. Anyone attending this section or when checking in could potentially see patient identifiable information from the two monitors behind the reception desk. This was also visible through the window of the small private room. We raised this issue with the practice manager and she verbally assured us that they would order immediately and install a privacy screen filter on the monitors.

Information governance was good in relation to the security of electronic patient data and their medical records. Hard copies of medical notes were stored securely, in an offsite location.

Improvement needed

The practice is required to provide HIW with details of the action it will take to ensure that:

- Full length glass doors are installed between the reception and office to the rear of reception.
- Installation of a privacy screen filter on the monitors behind the reception desk.

## Record keeping

As previously described, we reviewed a sample of patient medical records. These were in an easy to navigate electronic format, and were secure against unauthorised access.

Entries made in the medical records were clear and concise. The notes made were sufficiently detailed to help inform decision making at subsequent consultations and so plan patients' ongoing care and treatment. 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. The records showed that entries had been made in a timely manner following each consultation. We saw that Read codes[12] were used effectively within the sample of medical records we reviewed.

Arrangements were described for summarising information in patients' electronic medical records. We were told that only clinical staff summarised records. Summarising information helps ensure that GPs and nurses have easy access to a patient's relevant past medical history to help inform care and treatment decisions effectively and efficiently.

We did not identify a process in place for regular audit of the quality of data entry within patient records, measured against an agreed standard, and senior staff confirmed that audits of patient records were not routinely completed.

Improvement needed

The practice is required to provide HIW with details of the action it will take to ensure that:

- Regular audit of data entry within patient records is undertaken, as part of quality assurance activity.

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

## 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.*

Overall, we found that the practice was generally well run. The staff team were happy in their work and said that they felt well supported. The whole staff team also had a patient centred approach.

We identified that some written policies and procedures would benefit from being reviewed to ensure they reflect current arrangements at the practice.

Improvement was also needed around demonstrating that suitable recruitment checks are fully completed.

### Governance, leadership and accountability

At the time of our inspection, the practice was owned and operated by five GP partners. A full-time practice manager was also in post and was responsible for the day to day management of the practice. She also managed the branch practice in Pentwyn.

There was a designated GP as lead for governance, quality assurance and quality improvement. There was also an electronic clinical governance file available however, we did not see evidence of audits, their results or any actions from these.

All medical and nursing staff seemed individually motivated to keep up to date with health initiatives, guidelines and awareness of national patient safety alerts. However, there was a lack of clinical leadership to ensure dissemination and action planning of such information, to ensure these were applied within the practice.

We found that the team of administrative staff had a number of roles and responsibilities. This meant that staff could provide cover for each other during absences, reducing the risk of disruption to services for patients. We were told that there were two new members of reception staff who were currently learning the key processes and procedures.

There was a clear willingness and motivation within the practice team to support and develop new and existing staff through shared and experiential learning, to improve the services provided to patients. However, we did not see evidence of regular external study days or courses. This was because the practice did not hold an easily accessible training matrix or evidence of training certificates to record and monitor any training undertaken by the medical, nursing or administrative staff.

The use of a completed training matrix and holding copies of training certificates would ensure that any update training would be booked and attended promptly before expiry. In addition, where the nursing team require evidence of training (learning and participatory) for the purpose of the Nursing and Midwifery Council (NMC) revalidation[13]; then this could be easily accessed in advance of revalidation dates. This is particularly so for the practice manager, since she told us that she is partly responsible for sign off, within the three yearly revalidation process.

Clinical cases were reported as being discussed on a daily but informal basis between GPs. However, nursing staff were not present or invited to those meetings. The inspection team therefore advised, that all relevant clinical staff should be involved in regular set clinical meetings for the purposes of learning and continuity of patient care.

There were weekly practice meetings between the GPs and practice manager, and the meeting mixed business and clinical topics. There was no agenda or minutes therefore, no formal records made to ensure that actions were followed through and who was responsible for them.

[13] Revalidation is the new process that all nurses and midwives must go through in order to renew their registration with the NMC.

Other staff meetings were usually held once a month as previously highlighted, however, these were informal and with the absence of meeting agenda's and minutes. Whilst there was some evidence of information giving (which was relevant to practice functions), there was little evidence of the promotion of two way discussions and opportunities for staff to offer suggestions and ideas.

As previously highlighted, the practice was part of a local GP cluster. We were told that the GPs and practice manager attended local cluster meetings regularly. This helps promote cluster working and engagement as well as some shared learning. However, there was no evidence of how relevant information from these cluster meetings is disseminated to other doctors in the practice and practice staff.

The practice had in place a three year practice development plan. This identified a number of actions to maintain and develop the services provided and included timescales for completion.

A range of written policies and procedures was available electronically to guide staff in their day to day jobs. Staff we spoke to were aware of how to access these. Whilst policies and procedures were in place, we identified that many did not reflect the current arrangements as described by staff, and the majority required updating and with version control.

Improvement needed

The practice is required to provide HIW with details of the action it will take to ensure that:

- A review and update is undertaken of the practice policies and procedures to ensure that they accurately reflect the current arrangements at the practice and that they are up to date along with version control
- Relevant audits are undertaken and results, actions and outcomes are shared through the team
- A record of all mandatory training attendance and other relevant training, is recorded for all staff working within the practice.
- Relevant information from cluster meetings is shared with GP partners and practice staff and demonstrate how cluster developments are included in the practice development plan.

## Staff and resources

### Workforce

The practice staff that we spoke to were able to describe their particular roles and responsibilities, which contributed to the overall operation of the practice. Staff working within the practice took on dual roles and worked flexibly. This meant that staff could provide cover for each other during absences as highlighted earlier, to reduce the risk of disruption of services to patients.

Comments from staff indicated that they were supported to attend internal and some eLearning/training relevant to their role. Training information provided by senior staff showed that not all staff were up to date with mandatory training as highlighted above.

Arrangements were described for staff annual appraisals and we saw examples of completed appraisals within the sample of staff files we reviewed. An annual appraisal process will help identify the performance, training and development needs of staff. This can also provide an opportunity for managers to provide staff with feedback about their work.

We reviewed a sample of staff files. Not all staff had evidence on their file to show that recruitment checks, such as written references and also a Disclosure and Barring Service (DBS) check to the required level, had been conducted to demonstrate they were suitable to work at the practice. In addition, we did not see any evidence that there was a robust induction plan in place that would cover all aspects of induction along with mandatory training requirements.

Improvement needed

The practice is required to provide HIW with details of the action it will take to ensure that:

- All staff have completed and are up to date with mandatory training
- Suitable recruitment checks have been completed for example, appropriate level of DBS check for each staff member, and references on file to ensure that staff are suitable to work at the practice
- A robust induction list is in place to ensure a standardised approach with all members of staff new to the practice.

# 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, measurable, 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: Pontprennau Medical Centre

## Date of inspection: 5 November 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 assurance issues. | | | | |

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:** Pontprennau Medical Centre

**Date of inspection:** 5 November 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 it will take to ensure that:<br><br>All patients have equal access to relevant health promotion information within the practice<br><br>For the provision of leaflets for patients to read and take away. | 1.1 Health promotion, protection and improvement | As a practice we are trying to promote a paperless environment therefore we intend to create a bank of leaflets saved to our shared drive that can easily be printed on patient request.<br><br>This service is already advertised on our 3 patient information screens throughout the practice. In addition our website contains a variety of information and self-help leaflets which we constantly monitor | Deputy Practice Manager | Ongoing due to changes in requirements |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| The practice is required to provide HIW with details of the action it will take to ensure that:<br><br>All patients are aware of the availability of a chaperone prior to receiving consultation or treatment, within the waiting area and relevant rooms<br><br>Information for the provision of a chaperone is clearly displayed for all patients within the waiting area and consulting/ treatment rooms. | 4.1 Dignified Care | Information regarding our chaperone policy is available on our 3 patient information screens throughout the building and also on the notice boards in our 2 waiting rooms.<br><br>Since the inspection we have included the chaperone policy poster in every clinical room. | Deputy Practice Manager | Completed |
| The practice is required to provide HIW with details of the action it will take to ensure that:<br><br>The patient information leaflet is updated to include relevant reference to the NHS Wales Putting Things Right process<br><br>All patients are aware of the Putting Things Right process by displaying | 4.2 Patient Information | The NHS Wales Putting Things Right process is already displayed in our 2 waiting rooms in both welsh and English. In addition information leaflets are already available on request from Reception and from our practice website.<br><br>This information has since been added to our practice leaflet. | Deputy Practice Manager | Completed |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| this appropriately within the practice<br><br>That Putting Things Right information leaflets are readily available for patients to read and take away. | | | | |
| The practice is required to provide HIW with details of the action it will take to ensure that:<br><br>The process of informing doctors of matters that required urgent attention using post-it notes is reviewed, to ensure robust communication and to ensure appropriate action has been taken when in relation to patients<br><br>A robust additional follow up process is implemented and is auditable, to ensure that where applicable, patients have attended a follow up appointment or collected their prescription to commence necessary treatment<br><br>The documentation and information provided within hospital discharge | 3.2 Communicating effectively | In regards to informing doctors of urgent messages we intend to trial a daily workbook which will be kept in the admin room. The clinicians can review and action the messages and the team will have a record of the completed tasks. At the end of the day this book will be audited by the admin team to ensure all tasks are completed.<br><br>A protocol is now in place to ensure follow up of all results ensuring that patients are recalled. This is audited by the admin team on a weekly basis.<br><br>Any illegible discharge summaries are returned to the relevant department and requested again. As the majority of hospital discharge summaries come to the practice electronically we will continue to electronically forward them | Practice Manager/Deputy Manager | End of January 2019 |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| summaries to GP's, is reviewed to maintain robust communication. | | to clinicians for action. | | |
| The practice is required to provide HIW with details of the action it will take to ensure that:<br><br>The availability of appointments on the day and booking in advance is reviewed<br><br>All patients are aware of how to access the out of hours GP service<br><br>The provision of telephone access only to a GP service between the hours of 5.30pm and 6.30pm is clearly communicated to the surgery's patients because the health boards' out of hour's service does not commence until 6.30pm. | 5.1 Timely access | The practice regularly reviews the appointment system and takes on board patient feedback. Since the inspection date the practice has employed an additional salaried GP to create more same day appointments and pre-booked appointments which has enabled the GP partners to review their working schedule and create more flexibility with appointment times.<br><br>The out of hours telephone message clearly states that emergency service is available in the interim period of 5.30pm to 6.30pm. We have added details on how to contact the out of hours service to our opening times board at the front of the practice. | Practice Manager | Completed |
| The practice is required to provide HIW with details of the action it will take to ensure that:<br><br>Access through the entrance doors is | 6.1 Planning Care to promote independence | The practice has already submitted an application request for an Improvement Grant to install automatic doors at the main entrance to the building. | Practice Manager | Ongoing |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| reviewed to ensure all patients can enter safely and independently.<br><br>Fair consideration is made in relation to parking for patients at the practice, particularly for those with mobility issues.<br><br>Review of the patient registration form is required, to ensure all impairments are captured such as, mobility issues. | | The main patient car park is preserved for patients with appointments at the surgery. Any ancillary staff members park offsite to ensure this. We have also made changes to our appointment system to ensure a more timely flow of patients throughout the day. In addition to this we have entered communications with the local council to address the parking concerns in the vicinity.<br><br>The patient registration form has already been updated since the inspection. | | |
| The practice is required to provide HIW with details of the action it will take to ensure that:<br><br>It will develop a system for the recording and response to verbal concerns or complaints received from patients or relatives/carers, in-keeping with the Putting Things Right process. | 6.3 Listening and Learning from feedback | All verbal complaints/concerns are now documented in the shared drive alongside the written complaints folder. | Practice Manager | Completed |
| **Delivery of safe and effective care** | | | | |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| The practice is required to provide HIW with details of the action it will take to ensure that:<br><br>The business continuity plan is updated<br><br>All staff where applicable complete a risk assessment and are trained for the use of display screen equipment. | 2.1 Managing risk and promoting health and safety | Business Continuity Plan will be updated.<br><br>Staff risk assessment had already been completed at time of inspection but not asked for.<br><br>Display screen equipment training to be completed for new staff and updated for existing staff in the New Year. | Practice Manager/Deputy Manager | End of January 2019 |
| The practice is required to provide HIW with details of the action it will take to ensure that:<br><br>The infection control policy is reviewed to reflect the newly renovated environment, and for it to include reference to relevant procedures. | 2.4 Infection Prevention and Control (IPC) and Decontamination | The updated policy is to be completed. | Deputy Manager/Practice Nurse | End of February 2019 |
| The practice is required to provide HIW with details of the action it will take to ensure that:<br><br>A consistent approach by clinicians is promoted with recording reasons for prescribing or discontinuing medication within patients' medical | 2.6 Medicines Management | GP partners have decide on an agreed approach for documenting changes in patients' medication. Any medication which is removed will have a reason entered.<br><br>Practice nurse will check emergency | Clinical Team | Completed |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| records<br><br>Emergency equipment is checked and recorded weekly<br><br>Ensure all practice staff complete annual resuscitation training. | | equipment weekly instead of monthly.<br><br>Resuscitation training was scheduled for two weeks after the inspection date and has now been completed. Any staff unable to attend that session have already been booked for the New Year. | | |
| The practice is required to provide HIW with details of the action it will take to ensure that:<br><br>Every member of staff has undertaken safeguarding training for children and adults and that all staff receive regular training updates. | 2.7 Safeguarding children and adults at risk | Hard copies of certificates to be obtained from all members of staff to keep on file. New staff members are to take part in training in the New Year. | Practice Manager | End of January 2019 |
| The practice is required to provide HIW with details of the action it will take to ensure that:<br><br>Significant events and new guidelines are always shared with staff in a formal and timely manner. | 3.1 Safe and Clinically Effective care | All significant events meetings are documented and staff are informed by email of new significant event to be viewed on shared file | Senior partner/Practice Manager | Ongoing |
| The practice is required to provide HIW with details of the action it will take to ensure that: | 3.4 Information Governance and Communications | Inspectors were informed on the day that doors for this area have been ordered and are awaiting installation. As | Practice manager | Ongoing |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| Full length glass doors are installed between the reception and office to the rear of reception to maintain confidentiality.<br><br>Installation of a privacy screen filter on the monitors behind the reception desk. | Technology | this is a bespoke product there is and 8 week delay.<br><br>Privacy screen filters have already been installed. | | |
| The practice is required to provide HIW with details of the action it will take to ensure that:<br><br>Regular audit of data entry within patient records is undertaken, as part of quality assurance activity. | 3.5 Record keeping | An audit of record keeping and data entry into the patient record will be undertaken and the information shared and then re audited after six months and then annually. | Dr M Pomeroy | On going |
| **Quality of management and leadership** | | | | |
| The practice is required to provide HIW with details of the action it will take to ensure that:<br><br>A review and update is undertaken of the practice policies and procedures to ensure that they accurately reflect the | Governance, Leadership and Accountability | Practice policies and procedures are in the process of being updated.<br><br>The GP cluster lead will distribute minutes from all cluster meetings.<br><br>Audit of data entry will be shared throughout the practice team. Any future | Dr Pomeroy | Ongoing |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| current arrangements at the practice and that they are up to date along with version control<br><br>Regular audits are undertaken and results, actions and outcomes are shared through the team<br><br>A record of all mandatory training attendance and other relevant training, is recorded for all staff working within the practice.<br><br>Relevant information from cluster meetings is shared with GP partners and practice staff and demonstrate how cluster developments are included in the practice development plan. | | audits and significant events analysis to be shared with the entire practice team.<br><br>Copies of mandatory training to be obtained and kept in all staff members personal files. | Practice Manager | April 2019 |
| The practice is required to provide HIW with details of the action it will take to ensure that:<br><br>All staff are up to date with mandatory training | 7.1 Workforce | All clinical staff are already DBS checked. Administrative staff to be checked in the New Year.<br><br>Staff induction list has been updated since inspection. | Practice manager | End of April 2019 |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| Suitable recruitment checks have been completed for example, appropriate level of DBS check for each staff member, and references on file to ensure that staff are suitable to work at the practice<br><br>A robust induction list is in place to ensure a standardised approach with all members of staff new to the practice. | | All staff will have updated mandatory training completed by 30th April. | | |

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):** **Julie Fraser**

**Job role:** **Practice Manager**

**Date:** **01.02.19**