Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

The Lawn Medical Practice, 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 healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do. We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an announced inspection of The Lawn Medical Practice, Aneurin Bevan University Health Board on 8 November 2022.

Our team for the inspection comprised of two HIW Healthcare Inspectors and three clinical peer reviewers. The inspection was led by a HIW Healthcare Inspector.

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the setting and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Overall, we found that the service strived to provide a positive and caring experience to patients, and we witnessed clinical and non-clinical staff speaking to patients in a kind and helpful manner. We were assured by the provisions in place to ensure patient dignity and privacy was upheld.

The practice could improve the provisions in place for the gathering of patient feedback and to ensure an 'Active Offer' of Welsh was provided to patients.

We found that a significant number of complaints relating to a particular theme had shown little improvement and this could impact on the overall patient experience. As such we would urge the practice to reconsider actions taken in response to these to ensure improvement in this area.

This is what we recommend the service can improve:

- Develop an effective system to escalate complaints should a theme emerge
- Consent forms and information available in a range of formats (e.g. Easy-Read, large print)
- Develop and encourage the Welsh 'Active Offer'.

This is what the service did well:

- Smoking cessation champion and wellbeing practitioner available for self-referral by patients
- Provision of a variety of ways to book appointments, including telephone
- Modern, bright, and welcoming practice with easy access for patients with mobility access requirements, which included disabled parking facilities and level access as well as a hearing loop system.

Delivery of Safe and Effective Care

Overall summary:
Overall, we found that the practice did not always offer patients safe and effective care. Most notably, we found that the practice lacked robust safeguarding policies, procedures, and practices, in particular in regard to children considered as 'looked after', 'in need' or those on a child protection plan with the local authority.

Our review of the medical records identified that patient records often lacked sufficient details. Correspondence received from secondary care providers was not always overseen by a general practitioner (GP).

Emergency drugs and equipment were not checked in line with Resuscitation Council (UK) guidelines and did not contain the required medicines when undertaking a minor surgical operation. We found that prescription pads and materials were not safely stored to prevent inappropriate handling or use.

We found evidence of good practice regarding appropriate storage of refrigerated medicines, with regular temperature checks that were logged twice daily and spot checks for completion.

Immediate assurances:
HIW were not assured that the practice had a robust and effective procedures to ensure the safeguarding of children and vulnerable adults. During the inspection HIW undertook a review of a sample of patient records, these lacked sufficient detail to ensure vulnerable or at-risk children were always appropriately safeguarded. Patient records were not always complete and contemporaneous.

We were also not assured that the medical practice had in place an appropriately trained Infection Prevention and Control (IPC) lead nurse and we were not provided with evidence of audits of IPC and hand hygiene undertaken at the medical practice.

Lastly, we were not sufficiently assured that staff working at the practice had undertaken sufficient training to competently carry out the tasks they were assigned.

This is what we recommend the service can improve:

- Implementation of a robust system of adherence to the All-Wales Safeguarding Procedures. In particular regarding children considered ‘looked after’, ‘in need’ or a child protection plan with the local authority
- Review of record keeping and implementation of an ongoing audit of record keeping including assessment of correspondence oversight by GPs and assurance of full and contemporaneous record keeping
- More frequent checking of emergency drugs and equipment in line with Resuscitation Council (UK) guidelines to ensure all necessary medicines are available when carrying out minor surgical operations
- Implementation of improved infection prevention and control procedures to include formal training for the IPC lead nurse, implementation of audits such as hand hygiene, overall IPC compliance and a healthcare waste audit.

This is what the service did well:

- The practice was tidy, uncluttered and was visibly clean

- Clinical waste including sharps waste was labelled and handled appropriately
- The practice had in place suitable provisions to protect against the risk of respiratory transmitted illness
- Variety of methods for the reordering of repeat prescriptions by patients.

Quality of Management and Leadership

Overall summary:
On the day of our visit, we were not assured that there were robust systems in place to ensure the effective running of the medical practice. Although staff were witnessed working well together, during our discussions senior staff expressed concern about the sustainability of the practice in the longer term.

Compliance with mandatory training was assessed to be poor and senior management had not provided staff with annual appraisals for some years. Staff meetings were not undertaken on a regular basis and there was little opportunity for shared learning. We found that practice policies were generic in nature and often contained insufficient detail and the practice did not participate in an appropriate system of audit.

Immediate assurances:
HIW were not assured that the management systems and procedures in place were sufficiently robust to ensure adequate governance, and effective leadership and oversight of the practice.

This is what we recommend the service can improve:
- Implementation of robust storage systems for prescription pads
- Reimplementation of staff appraisals
- Completion of mandatory training in line with General Medical Council (GMC) guidelines
- Implementation of an audit schedule and programme.

This is what the service did well:
- Friendly and encouraging practice management
- Comprehensive staff files
- Staff were encouraged to increase their skill set should they wish.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Patient Feedback

Before our inspection we invited the practice to hand out HIW questionnaires to patients to obtain their views on the service provided at the practice. The practice did not return any patient experience questionnaires to HIW for inclusion within this report.

Staying Healthy

Health Protection and Improvement
On the day of our visit, we saw that the medical practice had an abundance of written health promotion information and advice available for patients. The waiting room had several different notice boards in strategic locations that contained information posters and graphics promoting a healthy lifestyle and there were plenty of leaflets with information regarding this for patients to take away with them.

Senior staff informed us that the medical practice benefitted from a smoking cessation champion, and we saw that information and leaflets advising on this service were available. Additionally, the medical practice had a wellbeing practitioner and a physiotherapy service available for patients. Although neither of these services were advertised on the medical practice website, we were told by senior staff that patients were able to self-refer.

We saw that the medical practice had a mental health nurse that was available for patients once per week. This was a service that required an initial assessment following referral from one of the GPs at the practice and patients were advised of this service via the medical practice website.

Dignified care

Communicating effectively
Our observations during the day of our visit demonstrated a friendly and helpful reception team who we witnessed greeting patients in a professional and welcoming manner.

We saw that the reception desk had a screen installed that separated the reception area from the waiting area. This aided private and confidential conversations.

Consulting and treatment rooms were located away from the main waiting area. We observed that doors to consulting rooms would be closed when in use. We saw that consulting rooms had curtains that could be pulled to preserve patient dignity during examination to provide a greater level of privacy to patients.

We were informed by senior staff that chaperones were available for patients if they needed them, and we were provided with evidence of a policy that covered this. Chaperone availability was advertised to patients via notices displayed within consulting rooms. Staff providing this service were usually members of the nursing team and occasionally members of the administration team. However, we found that non-clinical staff had not undertaken any training to carry out this role and training for clinical staff had not been renewed for some time. We were therefore not assured that all staff asked to undertake this role would fully understand their responsibilities.

Patient information
The medical practice had an informative website available to patients. This provided details of the staff team, opening hours and arrangements for accessing out of hours help and advice. There was also information on how to order repeat prescriptions and the telephone numbers for local health services such as dentistry and the nearest emergency department. We saw links to smoking cessation services as well as charities for mental health and Alzheimer's support.

Whilst there was bilingual signage within the medical practice, we found little information available through the medium of Welsh. Senior staff informed us that the practice did not have any Welsh speaking members of staff and the patient cohort used English as their primary language. We would recommend that the medical practice ensures availability of Welsh language documents and information leaflets. We would also encourage the practice to provide a translation service when required to ensure that an 'Active Offer' of Welsh is maintained in line with NHS guidelines.

We saw that information on the NHS complaints process, Putting Things Right, was displayed on a dedicated noticeboard within the waiting area. Information on how to make a complaint directly to the practice was also available on the medical practice website.

Timely care

Timely Access
The Lawn Medical Practice was open between the hours of 8am to 6:30pm Monday to Friday. Access to an appointment was available via digital means (e.g., My health online or e-consult) or by telephoning the medical practice directly. The practice also allowed patients to attend in-person to book an appointment.

Patients telephoning the practice for an appointment would first be screened by a member of the reception team. We were told that reception staff would also be responsible for signposting patients to other sources of help, such as the common ailment scheme, available through the local pharmacy, dentist, or optician when appropriate.

Triaging of patients requesting an appointment was shared between a specialist triage hub that was provided remotely and the medical practice. The triage hub was funded by the medical practice and was available remotely, three days per week during which time a limited number of patients would be triaged. Outside of this, responsibility fell to the GPs and Advanced Nurse Practitioners (ANPs) working at the medical practice.

We spoke to senior staff to understand the training undertaken by the reception team when screening patients prior to triage. We were told that training was provided in-house by an ANP. A flow chart was also used to further assist the reception team when prioritising patients for triage. Staff informed us that should they be unsure they would be able to approach a member of the clinical team for guidance.

We enquired about the arrangements for vulnerable patients or those with carers to access appointments. We were told that these patients would be given an in-person appointment at a time that suited them. We were provided with an example of a patient who was able to book an in-person appointment via attendance at the medical practice as they were unable to use digital methods or the telephone.

Patients requiring a home visit would be screened, triaged, and booked an appointment within a dedicated time slot with a GP. Staff informed us that visits to local care homes would be conducted by the ANPs at the practice.

We spoke with senior staff about the arrangements in place for patients requiring urgent appointments when none were available at the practice. We were told that patients requiring urgent appointments would be seen the same day. Children under five years of age would be prioritised.

When assessing the provision in place for support for those patients who may present in a mental health crisis or requiring urgent mental health support, we were told that clinical staff had access to the telephone numbers for the mental health and crisis teams. Additionally, the GP practice shared a building with the local mental health team. This meant that should they need to, clinicians seeing patients presenting in a mental health crisis were able to telephone for advice.

We were told that patients were able to access minor surgical operations through the medical practice as one of the GPs specialised in this area.

We were not assured at the time of our visit that the practice had in place a robust mechanism to ensure staff providing clinical results to patients were appropriately trained and competent to do so. As a result, this matter was dealt with under the HIW immediate assurance process, whereby we wrote to the practice within two days of the inspection, requesting immediate improvement. We have since received satisfactory assurance of improvement

Individual care

Planning care to promote independence

The Lawn Medical Practice was located within a purpose-built integrated health and social care building containing a second medical practice, a dentist, and a wealth of primary care services such as community midwives and health visitors.

From our discussions with senior staff, we found that the medical practice served a population with high deprivation and was located within the most deprived quintile of Caerphilly County Borough Council.

We were told that the medical practice had been offering the winter flu vaccination. However, despite encouragement, uptake within the patient cohort was reported by senior staff to be poor, with only those over the age 65 years old consistently taking up the offer of the vaccine. This was despite appointment availability on a range of dates and times to suit need.

The consent policy for the practice was compliant with ensuring patients provided informed consent. However, this was not available in an easy-read format, large print or in Welsh. Senior staff told us that this was because this was not needed within the patient cohort. We would recommend that the practice has the facility to provide this information for patients in alternative formats, such as easy-read, large print or Welsh.

We were told that the practice had a hearing loop to assist those patients with hearing difficulties and there was level access to the practice. The medical practice further benefitted from ample car parking including dedicated disabled parking bays.

People's rights

Senior staff informed us that the practice did not have an Equality and Diversity Policy and we were not provided with evidence of Equality and Diversity training undertaken by staff.

We asked senior staff about the arrangements in place to ensure that patients were treated fairly and were not discriminated against due to any protected characteristic.

We were told that the medical practice had in place an anti-discrimination policy. The practice did not monitor diversity of the patient cohort at the time of our visit. We found that transgender patients were treated sensitively, with a prompt response to any disclosure. We were told that records would be changed to reflect the use of any new name and pronouns and a new NHS number would be issued to the patient in a timely manner to ensure they were appropriately placed.

Listening and learning from feedback

Senior staff informed us that they did not routinely gather patient feedback on the service. However, patients would actively engage with social media channels used by the practice.

On the day of our visit, we saw that a patient suggestion box was available although we were told that this method of feeding back to the practice was rarely used by patients.

Senior staff stated that patients were not keen to become involved with the Patient Participation Group previously set up by the practice and this had unfortunately disbanded some time ago. We would encourage the practice to reconsider whether the Patient Participation Group would be beneficial to the practice.

The complaints policy and procedure adhered to the NHS Putting Things Right procedure. This provided clear guidance to patients and their carers should they wish to raise a complaint. We saw that the practice manager was responsible for managing complaints received by the medical practice and all complaints were kept in a dedicated log. We saw that the practice had a dedicated noticeboard within the waiting area to inform patient about the NHS Putting Things Right procedure and this was also included on the medical practice website.

We were told that informal discussions would be held with relevant staff where appropriate to discuss positive and negative feedback received from patients to encourage improvement whenever possible.

The review of the patient complaints log held by the practice showed that the practice had received a number of complaints regarding a particular member of staff. We noticed that each complaint regarding this had been responded to in a timely and appropriate manner. However, we explored with senior staff the reasons for a lack of improvement in this area. This revealed that the practice did not have a robust process for the management of complaints, including escalation where necessary, to ensure improvements where themes and trends were identified.

We were not assured that the practice had in place a robust mechanism to identify and act to ensure improvement in common themes arising because of patient complaints. As a result, this matter was dealt with under the HIW immediate assurance process,

whereby we wrote to the surgery requesting immediate improvement. We have not received satisfactory assurance of improvement.

Delivery of Safe and Effective Care

Safe Care

Managing risk and promoting health and safety
The medical practice was located within a purpose-built health centre. Our observations of the patient areas found that these were tidy and uncluttered. We noted that sharps bins were appropriately stored within clinical areas. Sharps bins were seen to be appropriately labelled, signed, and dated.

We were provided with the Business Continuity Plan. However, this was only available as a set of partially completed templates. In addition, this plan did not adequately cover the business partnership risk and the cascade sheet, for ensuring team members were aware of any emergency, was incomplete. We saw that the practice had a generic pandemic contingency plan on file.

We noted that the practice had a suitable mechanism for calling for help urgently within the practice and staff appeared knowledgeable of this.

Emergency equipment was in a nurse treatment room. There was a sign on the door indicating the oxygen and emergency drugs and equipment was in this room. Its location was known to all staff members.

The practice offered a minor surgical operations service to patients. However, during our review of this particular service, we noted that the practice did not have atropine readily available to treat bradycardia, when undergoing a surgical procedure. This drug should be available while undertaking minor surgical operations. We were not assured that the practice had in place suitable mechanisms to ensure the safety of patients undergoing minor surgical operations at the practice. As a result, we dealt with this matter under the HIW immediate assurance process, whereby we wrote to the surgery requesting immediate improvement. We have since received satisfactory assurance of improvement.

We were told by senior staff that the practice did not work effectively with the cluster group to improve care for patients. This was said to be due to the relevance of the meeting contents.

Infection prevention and control (IPC) and Decontamination
Our observations of IPC and decontamination procedures at the medical practice revealed a visibly clean environment that was free from dust. Equipment was stored appropriately and appeared well organised.

Consultation rooms had ample handwashing facilities and sinks were fitted with elbow operated taps with appropriate hand washing instructions available. Waste bins were foot operated, and we saw that flooring was of a suitable wipe clean design. Clinical areas had wipeable surfaces.

Although we found that clinical areas were maintained to enable effective cleaning, we were not provided with evidence of daily cleaning schedules for the practice. To ensure all areas of the practice are consistently and regularly cleaned, we would recommend that the practice implements cleaning schedules and checklists for all areas of the practice.

Observation of clinical waste management demonstrated adherence to IPC guidelines. We were told that clinical waste was removed by the cleaning staff who were also responsible for removal of locked sharps bins from the practice to a locked clinical waste container outside the practice ready for collection by an approved contractor.

The practice had a comprehensive infection control policy dated within the last 12 months. However, we were not provided with evidence of audits undertaken to identify areas for improvement or adherence with IPC procedures in place. Notably, the practice had not undertaken an annual healthcare waste audit, or an audit of infection control and we were not provided with evidence of a hand hygiene audit. HIW recommends that IPC audits are undertaken promptly and an action plan for areas requiring improvement implemented.

Our review of the vaccination status of staff indicated that all relevant staff completed a satisfactory course of Hepatitis B immunisations. A record of this was kept within the staff files. Senior staff informed us that all staff had been offered and accepted the COVID-19 vaccination.

We noted that the practice had in place a policy for sharps or needlestick injuries. Should a member of staff receive a needlestick injury, we were told that a prompt referral to the occupational health team provided by the health board would be made. Alternatively, staff would be encouraged to attend the local accident and emergency department following a risk assessment.

Clinical rooms were found to contain appropriate personal protective equipment (PPE).

Due to the pandemic, the practice had implemented an isolation room for patients displaying symptoms of COVID-19. Face masks and hand sanitiser were also readily available to patients in the waiting area.

The practice had an IPC lead in place. This role was carried out by a member of the nursing staff. However, we were told that no formal training to carry out this role had

been provided. We were therefore not assured that the IPC lead had the necessary knowledge and skills to effectively undertake this role. We would recommend that the IPC lead completes the appropriate training.

Medicines management
Senior staff informed us of the process to allow patients to request a repeat prescription of regular medication. We were told that repeat prescriptions could be ordered in a variety of methods including the 'My Health Online' digital service, directly via chemists or the repeat prescription request slip could be handed into the reception desk at the practice. Requests would be actioned within 48 hours by the practice prescribing clerk.

We were told that the practice had an acute request list for medicines that had been previously prescribed but were not on a repeat prescription. Requests for acute medicines would be reviewed and, if necessary, a consultation required with a GP prior to prescribing. This prevented overuse of acute medications.

Long term medication reviews were undertaken by advanced nurse practitioners. This included reviews of medications used to treat chronic respiratory conditions, menopause and oral contraceptives. On the day of our visit, we were not provided with evidence to suggest that for each long-term condition or medication, the prescribing advanced nurse practitioner was appropriately trained and up to date. However, following the inspection we were provided with assurance from the setting and local health board of satisfactory training of staff to the required level. .

We questioned staff as to arrangements in place to ensure prescription pads and materials were stored securely. We were told that some prescription pads were stored behind the reception desk or otherwise stored in an admin office. GPs retained their own prescription pads, storing them in their own consulting rooms. Furthermore, the practice did not keep a log for the removal of prescription pads, or their location once removed. As a result of these findings, we were not assured that the practice was ensuring the security of prescription pads.

Senior staff informed us that the practice was not a dispensing practice with only vaccines and immunisations kept on site. We saw that the practice had designated clinical fridges for this. We were provided with evidence of twice daily temperature checks on the fridges. Staff told us that spot checks of vaccine expiry dates would occur. These were reported to have shown no concerns. We were told that clinical fridges used to store vaccines underwent annual testing to ensure they remained in good working order and alarms were present to alert staff should temperatures rise above strict parameters. We would encourage the practice to consider adding data loggers to their fridges to provide a log of temperatures when the practice is closed.

We reviewed the cold chain policy and found that whilst it provided some guidance for staff on the correct storage and transportation of cold chain medicines, there was not information on the steps to take should a breach in the cold chain occur. We would recommend that the policy be reviewed and amended to ensure confusion did not occur when there was a breach.

Safeguarding children and safeguarding adults at risk
We conducted a review of the safeguarding policies and procedures in place at the medical practice. Although the practice had a safeguarding lead, we identified that there was not have a robust mechanism in place to ensure children and vulnerable adults were safeguarded effectively. There was not a system in place for identifying adults at risk and overall, we found the safeguarding procedures at the practice to be disorganised.

The practice did not hold a safeguarding register for patients registered with them subject to safeguarding procedures.

Senior staff informed us that the practice had a safeguarding policy and that all staff had access to the All Wales Child Protection Procedures. However, we were not provided with evidence of this on the day of our visit.

We found that children on child protection plans, those regarded as children in need, or children looked after by the local authority were not always sufficiently safeguarded. We reviewed three sets of medical records belonging to children subject to safeguarding criteria by the local authority. Of these, we found that all were missing details of the named carer and were incorrectly read coded to accurately reflect their current safeguarding status.

No clear marker was consistently present within the patient medical records to identify children at risk. One child noted to be a child looked after by the local authority did not have up to date address details on their medical records.

Furthermore, correspondence sent to the practice by secondary care teams relating to children subject to local authority safeguarding procedures, was not provided to GPs for review. From our review of the medical records, we found that one child was not appropriately followed up by the practice, when they failed to attend for an appointment.

The practice further failed to act on actions stated explicitly within plans for children that were registered as looked after or on a child protection register.

Discussions with senior staff revealed that regular safeguarding meetings did not take place either as a practice or with the wider primary care teams such as health visitors or

midwives. This was said to be due to a shortage of staff. This meant a vital opportunity to share information between primary care teams was missed, posing a risk that prompt action might not be taken if necessary to protect vulnerable adults and children.

Despite verbal assurances on the day of our visit, we were not provided with evidence of recent safeguarding training for any member of staff.

We asked senior staff to tell us of the procedures in place to monitor Accident and Emergency attendance, frequent failure to attend appointments at the practice and appointments missed by children who were "not brought". We were told that this was not routinely reviewed, with only one patient identified by the Welsh Ambulance Service Trust and not by the practice themselves.

We were not assured that the practice had in place safe and robust safeguarding mechanisms to protect children and vulnerable adults. As a result, these matters were dealt with under the HIW immediate assurance process, whereby we wrote to the surgery requesting immediate improvement. We have not received satisfactory assurance of improvement in all areas.

Medical devices, equipment and diagnostic systems
On the day of our visit, we found that the medical devices and equipment were in a good state of repair and had been well maintained.

We saw that single use equipment was available for patients undergoing minor surgical operations at the practice.

Our observations of the emergency drugs checks undertaken at the practice found them to be undertaken monthly. Resuscitation Council (UK) guidelines stated that these checks should be undertaken on a weekly basis. As a result, we dealt with this matter under the HIW immediate assurance process, whereby we wrote to the surgery requesting immediate improvement. We have since received satisfactory assurance of improvement.

The practice had an Automated External Defibrillator (AED) which was kept with the emergency drugs and equipment and had both child and adult pads available. We were informed that staff checked the AED daily. Staff demonstrated knowledge of where to locate these items and we observed that a sign was present on the door of the room in which they were kept. Pulse oximeters were kept in individual clinician's rooms.

We saw that a mini fridge was located within one of the clinical rooms. We were told by staff that this was used solely by one of the GPs to store cold drinks. This was positioned in such a way as to stretch the electrical cable presenting both a trip hazard to patients and staff and also increasing the risk of an electrical fire. We noted that this item had

not undergone any portable appliance testing (PAT). We recommend that the practice repositions the fridge to prevent the risk of fire, trips and falls and ensures PAT testing is carried out on the fridge prior to using within the practice.

Effective care

Safe and clinically effective care

Senior staff confirmed the processes in place to circulate and disseminate patient safety alerts and learning from significant events. We were told that this would usually be undertaken using a messaging system available via a secure platform. Senior staff confirmed that significant event analysis meetings did not take place. We were told that this was because no significant events had taken place. No formal method for wider team learning and discussion was in place at the practice. Staff informed us that any incidents would be recorded via an electronic DATIX system.

Updates to clinical practice including national and professional guidance was disseminated via email to staff. Clinical staff were also encouraged to attend courses to ensure they were up to date with best practice guidelines where available.

Staff confirmed that referral requests would be added into the body of a consultation report. These would be sent to the practice secretaries for typing and sending via the Welsh Clinical Communications Gateway. We were told that a report was sent to the practice monthly regarding referrals for urgent suspected cancer referrals. We were also told that referrals rates would be discussed at cluster group meetings. This would enable the practice to identify any outliers for referrals and to explore the reasons for this.

Information governance and communications technology

We spoke with senior staff who confirmed arrangements for data security at the practice. We were told that the practice had a data protection officer who was appropriately trained. This was a service provided by Digital Health Care Wales.

The medical practice had a clear process in place for the handling of personal and sensitive data. The practice privacy policy was available for patients to view on the practice website and information was available for patients should they wish to access their information. Further information was available on a noticeboard in the waiting area of the practice.

Record keeping

We reviewed a sample of electronic patient medical records. Medical records were secured against unauthorised access.

Record keeping was found to be poor in the sample of notes reviewed on the day of our visit and we were not assured that the practice had in place systems to ensure complete and contemporaneous medical records. Overall, patient medical records were found to be difficult to navigate and important correspondence that had been saved within the medical records was often challenging to locate, making case tracking difficult to understand.

Correspondence requiring review by a GP was not always appropriately forwarded for this review to take place. Furthermore, correspondence was not always correctly read coded to ensure areas for concern were flagged appropriately.

Read codes relating to symptoms or illness were not always correct and at times were missing entirely from the medical records.

In some cases, entries made were not suitably detailed, containing insufficient information relating to the patients' condition and health. This included a lack of detail surrounding length and cause of symptoms and administration of acute medicines for respiratory symptoms within the home.

We were not provided with evidence of any continuous audit of patient medical records and would urge that the practice implement this to ensure full and contemporaneous record keeping that is correctly coded.

We were not assured that the practice had in place safe and robust mechanisms to ensure full and contemporaneous record keeping that was correctly read coded. As a result, these matters were dealt with under the HIW immediate assurance process, whereby we wrote to the surgery requesting immediate improvement. We have not received satisfactory assurance of improvement.

Quality of Management and Leadership

Governance, Leadership and Accountability
At the time of our inspection, The Lawn Medical Practice was owned and operated by two GP partners. The practice was part of a local GP cluster group. Although senior staff informed us that they attend regular cluster group meetings, we were told that they did not feel this was an effective use of resources.

The practice employed a number of clinical and non-clinical staff, including a third salaried GP, as well as advanced nurse practitioners, practice nurses and healthcare assistants.

The practice had in place an experienced business manager and had recently appointed a practice manager. There was also a business manager available for further support. However, due to our findings throughout the day of our visit, we did not feel that the leadership and management of the practice and staff was wholly effective in most areas of the practice.

We were told by senior staff that they felt the medical practice was not sustainable as a business. This was said to be due to an overwhelming and unsustainable workload and a lack of capacity for cover due to leave if required. We were provided with evidence of this that included staff rotas and the volume of workload expected each day evidenced by the appointment system.

We found that team meetings did not take place at the practice, instead management relied on messaging software available via the practice software. This was further affected by a lack of protected learning time provided by the local health board.

Clinical peer review did not appear to take place and we would recommend that this was implemented to ensure that areas for improvement or requiring further training were not missed.

During our discussions with staff at the practice, we received whistleblowing allegations relating to a particular staff member. These concerned the culture at the practice as well as allegations of bullying by senior staff and questions of probity. We spoke with senior staff about these concerns and were not assured that a sufficiently robust process was available to appropriately address or escalate them as necessary. We would recommend that the practice puts in place a policy and procedure to ensure that such allegations are sufficiently investigated, and actions taken as appropriate that are measured, specific and in line with professional guidance.

We found that The Lawn Medical Practice had a range of written policies and procedures in place provided by a compliance software for GP practices. These were available via a mixture of hard copy and electronic formats. However, these were largely generic in nature and not always specific or relevant to the practice. We recommend that the practice review the policies and procedures to ensure they are specific to the practice.

Workforce

We spoke to staff across a range of professions working at the practice. We found that staff were largely knowledgeable of their roles and responsibilities and worked hard to provide a quality service to patients.

Senior staff expressed difficulty in recruiting staff to vacant roles at the practice. Staff new to a role would not always be provided with an induction programme devised by senior staff. Instead, this would be developed by other nursing staff. This was not overseen by the practice management team. For experienced or long-term staff, there was little in the way of clinical supervision. Accordingly, we would recommend that the practice implements a more robust system of governance and a formal system of clinical supervision. Furthermore, we would encourage additional clinical governance to include an audit of non-medical prescribing consultations.

A review of mandatory training found very poor compliance. Although almost all staff had undertaken recent training in Basic Life Support, evidence of other mandatory training was not provided, and the practice did not have a mandatory training spreadsheet. We were told that fire training had last been completed prior to the pandemic and had not been repeated since. Furthermore, staff had not been encouraged to complete training in equality and diversity.

Senior staff informed us that training was the responsibility of the clinician with training for non-clinical staff to be guided by the health board, with no formal evaluation undertaken.

Staff appraisals had not been carried out for several years. We were told that it was felt that these were not needed as the practice manager and deputy practice manager had an ‘open door’ policy for staff to have informal discussions with them as they felt necessary.

We were not assured that the practice had in place safe and robust mechanisms to ensure effective management and leadership. As a result, these matters were dealt with under the HIW immediate assurance process, whereby we wrote to the surgery requesting immediate improvement. We have not received satisfactory assurance of improvement.

Our review of staff personal files found these to be largely comprehensive. Staff employed by the practice had in place a contract of employment and job description. Only a handful of staff had in place a recent disclosure and barring service (DBS) check. Where DBS checks are not required, we would encourage the practice to consider a procedure to ensure that staff employed at the practice continued to remain fit for employment within their roles.

4. Next steps

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 how the findings identified will be addressed
- 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
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

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.

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: The Lawn Medical Practice / Aneurin Bevan University Health Board

Date of inspection: 8 November 2022

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.

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Delivery of safe and effective care				
Finding HIW were not assured that the practice had a robust and effective procedures to ensure the safeguarding of children and vulnerable adults. During the inspection HIW undertook a review of a sample of patient records. We found the following issues which require immediate action by the practice to ensure the safety of children and vulnerable adults: • Lack of carer details for children registered as 'Looked after' or on a child protection plan by the local authority • Incorrect address details for children registered as 'looked after' or on a child protection plan by the local authority • Lack of oversight by GPs of correspondence regarding changes of safeguarding status of children registered as 'looked after' or on a child protection plan.				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
• Failure to act upon actions stated explicitly within plans for children registered as 'looked after' or on a child protection register • Incorrect coding of safeguarding status within the patient medical records • Failure to refer vulnerable adult patients disclosing incidents of abuse and/or harm to the local authorities safeguarding team in a prompt and timely manner • Within staff files we were unable to find evidence of current safeguarding training completed to the appropriate level • Failure to hold a safeguarding register • Failure to hold regular practice safeguarding meetings.				
Improvement needed The practice is required to: • Ensure patients subject to safeguarding are appropriately coded within the patient medical records • Ensure medical records contain up-to-date details for looked after children, children in need and those on a child protection plan in line with the most	**2.7 Safeguarding Children and Safeguarding Adults at Risk**			

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
up to date information provided by the local authority safeguarding team • Develop, implement, and maintain a robust procedure and mechanism to ensure full oversight of correspondence received concerning children and vulnerable adults subject to safeguarding procedures by the local authority • Regularly review and act upon actions set out by plans agreed for children and vulnerable adults as set out by the local authority safeguarding team • Develop, implement, and maintain a robust system to ensure the prompt and timely referral of patients, carers or guardians that disclose abuse or harm towards themselves or their child, or the person for whom they care				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
• Provide HIW with evidence of recent and up-to-date safeguarding training to the appropriate level for all staff (both clinical and non-clinical) • Develop, implement, maintain, and regularly review a safeguarding register • Develop, implement, and hold regular safeguarding meetings within the practice to ensure those patients on the safeguarding register are coded and safeguarded appropriately and to ensure staff are aware of their responsibilities in relation to the safeguarding of children and vulnerable adults • Regularly review patient notes and medical records to ensure ongoing adherence to safeguarding status and any plan implemented by the local authority safeguarding team.				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Finding HIW were not assured that the practice kept complete and contemporaneous medical records. We found the following issues that require immediate improvement to ensure patient records are complete, contemporaneous and allow for safe and effective care: • Correspondence received was not always appropriately forwarded to GPs and was not correctly Read Coded • Patient medical records were not correctly Read Coded and at times some visits and/or medical conditions did not contain any Read Codes. • Patient medical records were found to be difficult to navigate and important correspondence saved within the electronic medical records was challenging to locate.				
Improvement needed The practice is required to: • Develop, implement, and maintain a robust system to ensure correspondence received at the practice is given full oversight by the GPs.	**3.5 Record Keeping**			

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
• Implement an audit of continuous assessment of medical records to ensure notes are correctly and appropriately Read Coded.				
Finding HIW were not assured that the medical practice had in place an appropriately trained Infection Prevention and Control (IPC) lead nurse. This was because the nurse in charge of IPC had not undertaken any formal training to undertake this role. We were therefore not assured that the practice had robust procedures in place. Furthermore, we were not provided with evidence of audits of IPC and hand hygiene undertaken at the medical practice.				
Improvement needed The practice is required to: • Provide the lead IPC nurse with an appropriate training programme • Undertaken annual IPC audits	**2.4 Infection Prevention and Control (IPC) and Decontamination**			

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
• Undertake regular hand hygiene audits of staff.				

Finding

HIW were not assured that staff working at the practice had undertaken sufficient training to competently carry out the tasks they were assigned. During our inspection, HIW found the following issues that require immediate improvement to prevent patient harm:

- Advanced Nurse Practitioners (ANPs) providing respiratory medicines reviews for patients despite having not completed training in respiratory medicine
- Long term medication reviews conducted by ANPs
- Repeat prescription requests for Hormone Replacement Therapy (HRT) and the Oral Contraceptive Pill (OCP) undertaken by ANPs
- Healthcare Support Workers (HCSW) providing blood test results (including abnormal results) to patients.

HIW were also not assured that the practice had in place suitable arrangements for the checking of emergency medicines and equipment, and replacement of expired medicines and equipment.

We found the following serious issues at The Lawn Medical Practice which require immediate action by the setting to prevent harm to patients:

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
• The checking of emergency medicines and equipment was not in line with Resuscitation Council (UK) guidelines and was checked on a monthly rather than weekly basis. • We found that the practice did not have available a supply of atropine, which is necessary when undertaking minor surgical operations.				
Improvement needed The practice is required to: • Review prescribing practices to ensure that only those staff trained to do so are undertaking medication reviews for complex long-term condition medications • Ensure repeat prescription requests for the OCP and HRT medications is undertaken only by those staff with the appropriate training to do so • Ensure blood test results are only provided by clinical staff with the appropriate training.	**2.6 Medicines Management**			

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
• Ensure emergency medicines and equipment are checked on at least a weekly basis in line with Resuscitation Council (UK) guidelines • Obtain the medicines necessary when undertaking minor surgical operations				

Quality of management and leadership
Finding HIW were not assured that the management systems and procedures in place were sufficiently robust to ensure adequate governance, and effective leadership and oversight of the practice. During our inspection HIW found evidence of the following issues that require immediate improvement to ensure the practice operates safely and effectively: • Lack of mandatory training and oversight of this by senior staff • Failure to effectively audit the practice and its clinical practices • Insufficient practice policies that often-lacked detail and relevancy to the practice

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
• Insufficient and insecure prescription management systems • Inadequate opportunity for practice wide staff meetings and shared learning • No action taken on complaints regarding a common theme over 2021-22.				
Improvement needed The practice is required to: • Complaints are dealt with appropriately, robustly and in a manner to ensure improvement in common themes and trends • Develop, implement and maintain a mandatory training schedule to ensure staff are up-to-date with the requirements • Develop and implement a full audit schedule • Review the practice policies and protocols to ensure they are appropriate and relevant to the	**Governance, Leadership and Accountability**			

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
practice and provide the necessary details • Develop, implement, and maintain a prescription management system to safeguard the inappropriate use of prescription pads and other materials • Develop and maintain a practice meeting schedule with an appropriate agenda that allows for shared learning across the practice team • Ensure all staff have annual appraisals.				

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: The Lawn Medical Practice / Aneurin Bevan University Health Board

Date of inspection: 8 November 2022

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/ Regulation	Service action	Responsible officer	Timescale
The practice is required to: • Review and update of the Business Continuity Plan to include Business Partnership risks and an appropriate cascade sheet • Recommence discussion of significant events and serious event analysis to include team wide participation where appropriate.	2.1 Managing Risk and Promoting Health and Safety			

The practice is required to Implement and maintain a daily cleaning checklist and schedule.	2.4 Infection Prevention and Control (IPC) and Decontamination			
The practice is required to: • Check emergency drugs and equipment on a weekly basis in line with Resuscitation Council (UK) guidelines • Review and update the cold-chain policy • Implement a robust storage system for prescription pads and materials.	2.6 Medicines Management			
The practice is required to appropriately position the mini fridge in the GP treatment room so as not to cause a risk of fire, trips and falls. Any personal electrical equipment should be PAT tested before being used on the premises	2.9 Medical Devices, Equipment and Diagnostic Systems			

and this should include PAT testing for any personal appliances.				
The practice is required to develop and encourage the Welsh 'Active Offer'.	3.2 Communicating Effectively			
The practice is required to develop training for non-clinical chaperones.	4.1 Dignified Care			
The practice is required to add to the practice website details of services available to patient via self-referral.	4.2 Patient Information			
The practice is required to ensure consent forms and information is available in a range of formats (e.g. Easy-Read, large print).	6.1 Planning Care to Promote Independence			
The practice is required to: • Implement an Equality and Diversity policy	6.2 Peoples Rights			

• Provide appropriate training in this area for staff • Monitor patient diversity to ensure the service continues to meet patient needs.				
The practice is required to: • Recommence the gathering of patient feedback • Consider restarting a Patient Participation Group.	6.3 Listening and Learning from Feedback			
The practice is required to implement regular, minuted staff meetings to include the whole practice team where possible	7.1 Workforce			
The practice is required to implement an audit schedule and programme to ensure continual improvement	Governance, leadership and accountability			

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: