Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Llynfi Surgery, Cwm Taf Morgannwg 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 Llynfi Surgery, Cwm Taf Morgannwg Health Board on 23 January 2023.

Our team for the inspection comprised of one HIW Healthcare Inspector and four 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:
We found staff at Llynfi Surgery to be committed to offering a caring and friendly service to patients.

We observed the practice to be accessible for all patients, with a spacious waiting area, ground floor surgeries and a disabled toilet. The practice also had arrangements in place to protect the privacy and dignity of patients.

This is what we recommend the service can improve:

- Staff should ensure the records management policy is displayed in the practice waiting room for patients, rather than just on the practice website.

This is what the service did well:

- It was clear staff at the practice work hard to meet individual patient needs. This included arranging appointments during quieter times for autistic patients and always ensuring transgender patients are able to see their preferred clinicians
- The practice had full disabled access. All surgeries were situated on the ground floor and the main entrance doors were automated.

Delivery of Safe and Effective Care

Overall summary:
We were assured that patients attending Llynfi Surgery received safe and effective care. All clinical rooms were an appropriate size and generally kept tidy.

We reviewed a sample of patient records. All were legible and of a good quality. We also saw evidence of robust procedure in place to ensure medication in the dispensary is secure and accounted for.

This is what we recommend the service can improve:

- Staff must ensure that an environmental and infection control risk assessment are carried out as soon as possible
- Staff must ensure that clear links are noted between drugs prescribed and the clinical problem in patient records.

This is what the service did well:

- We saw evidence of a robust significant events matrix in place at the practice
- The practice had robust process in place for the monitoring and replacement of resuscitation equipment and emergency drugs.

Quality of Management and Leadership

Overall summary:
From discussions with practice staff, it was clear that they were committed to providing good patient care and were eager to carry out their roles effectively.

We saw evidence of regular staff meetings taking place and detailed minutes being recorded. These were accessible to all staff through a shared drive.

Immediate assurances:

- The practice must ensure that pre-employment checks for all staff include a DBS check appropriate to their roles
- The practice manager must ensure that all staff receive CPR training and that evidence of this is kept in staff files.

This is what we recommend the service can improve:

- The practice should update all practice policies, ensuring they are dated and contain a date for annual review
- All staff must complete equality, diversity, and inclusion training as soon as possible. Evidence of completed training should be recorded in staff files by the practice manager.

This is what the service did well:

- We saw evidence of a clear management structure in place at the practice.

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. We received 36 completed questionnaires, eight of which were completed on behalf of patient. Respondents provided the following comments:

> ***"Am satisfied with service."***
>
> ***"The service has drastically improved lately - very happy."***
>
> ***"Llynfi Surgery has had a lot of bad press lately which I think is completely wrong."***

Staying Healthy

Health Protection and Improvement

During our tour of the setting and conversations with senior staff, we were made aware of a number of health promotion initiatives advertised and promoted at the practice. We saw posters advertising pharmacy services, which included smoking cessation support, as well as information about weekly baby clinics. Staff told us that any new information would be clearly advertised in the waiting area and via the practice website. We were also informed of plans to set up weekly health care check clinics, covering support and advise around diabetes, heart disease, blood pressure, healthy lifestyle and diet advice.

The practice manager also informed us that the practice has good links with a mental health nurse, whom they can easily signpost relevant patients to. The nurse can then refer patients onto various mental health support agencies and treatments, including MIND, Mental Health Matters Wales and mental health retreats.

We were told that the practice also has access to a physio therapist who works across the cluster group. Patients can self-refer to this service and gain access to a walk-in X-ray clinic at the local hospital.

The practice had a robust follow up process in place for patients who do not attend their practice appointments. Staff informed us that patients who do not attend (DNA) three appointments receive a letter warning of removal from the practice.

This procedure was outlined in the practice DNA policy. Staff also informed us of the process in place for following up with parents or guardians for children who don't attend appointments. In such instances a letter will be sent to the parents or guardians and any concerns would be raised in the Safeguarding meetings held at the end of each month.

Dignified care

Communicating effectively

During our tour of the setting, we observed consultation and treatment room doors always being kept closed during appointments. Any conversations happening in treatment rooms could not be heard from outside. Not all GP surgeries contained curtains, however staff informed us that patients are given the option to move to a treatment room with curtains if they wish.

The reception desk was situated in a spacious waiting area. Staff confirmed no calls were taken at the main reception desk. We observed a team of reception staff in a room situated behind reception taking calls. This prevented any conversations being overheard in the waiting area. We were also told patients were able to have confidential conversations with staff if requested. They would be taken to an empty consultation or treatment room by a member of staff, away from the waiting area.

Our discussions with staff highlighted the practice's commitment to meeting patient individual needs. Although there is no hearing loop installed at the practice, the practice manager informed us that they current only have one deaf patient and they always access a sign language translation service for their appointments. The practice also has access to language line through the local health board and we were informed that staff will always ensure this is set up in advance for patient who require it's services.

Staff informed us that there are two Welsh speaking staff members at the practice, both of whom wear 'Iaith Gwaith' badges. The answerphone message for the practice is also bilingual.

When we arrived at the setting, there was very little bilingual information available to patients in the waiting area, however staff rectified this during our visit and ensured patient information, including the patient information leaflet and complaints procedure, were displayed bilingually before the end of our visit.

We saw evidence of a system in place at the practice to offer chaperones to patients who require it. Both male and female chaperones can be provided, and this was clearly advertised in the practice waiting area. There was a chaperone policy in place, and we were informed that only trained clinicians are used as chaperones.

We reviewed practice policies as part of our visit and discovered that there is currently no consent policy or triage policy in place at the setting. We reviewed the Care Navigation standard operating procedure and concluded that the relevant information for the consent and triage policies is located in this document. We informed staff that we require them to extract the relevant information and create the policies, referring back to the standard operating procedure where necessary.

Patient information

We viewed the practice website and saw that it provided information for patients. This included practice opening times, contact information, staff list and information for how to order repeat prescriptions.

The Putting Things Right complaints process and the practice own complaints procedure were displayed in both waiting areas at the setting. The setting's procedure aligns with the NHS policy and included all relevant information, including the staff member responsible for handling the complaints and the approximate timescales for providing a response.

We also reviewed the practice website and saw that the records management policy was available for patient information. However, this was not displayed in the waiting area of the practice for individuals who may have limited or no digital access. We recommend the practice display this document on both the practice website and on notice boards in communal areas.

Timely care

Timely Access

Llynfi Surgery opens between the hours of 8:30am to 6:30pm Monday to Friday and appointment can be accessed via telephone or by visiting the practice in person.

We were informed that the practice has an effective telephone system to allow for booking appointments. There is a queueing system in place for patients contacting the practice via telephone. This system keeps patients informed of the number of people ahead of them in the queue. Staff told us that patients are able to use the My Surgery app to cancel appointments, to save going back through the telephone system.

Staff told us about the range of appointment types available for patients. This included same-day, routine and follow- up appointments, all of which can be booked via telephone. We were informed that reception staff had received relevant training to successfully telephone triage, in order to determine the best next steps for the patient. Staff told us that the decision whether to book a face-to-face or telephone appointment is a shared decision between staff and the patient. We were informed that staff will always try and accommodate a face-to-face appointment for patients who request one.

We asked patients if they were satisfied with the opening hours of the practice and 31 of the 36 patients who responded were satisfied.Of the 35 patients who responded, 27 told us they were able to get a same-day appointment when they need to see a GP urgently and 23 out of 34 patients said they could get routine appointments when they need them.

Individual care

Planning care to promote Independence
The practice was fully accessible for all patients. The main entrance had automated doors which led into a spacious waiting area. There was a disabled toilet available for patients and all surgeries were located on the ground floor.

We reviewed the practice website and saw that google translate is available for use, making it accessible in a vast range of languages. However, we made a recommendation that signs be displayed, informing patients that documentation can be made available in both easy- read and parge print formats.

People's rights
Of the 36 patients who completed questionnaires, 17 either 'strongly agreed' or 'agreed' that staff at the practice treated them with dignity and respect. One patient answered with 'not applicable' and nine did not respond. Throughout the inspection we observed staff greeting patients in a friendly and welcoming manner.

The practice manager informed us of examples where reasonable adjustments are in place to ensure that all patients can access the services they require. Any difficulties patients have were flagged on their records, therefore reception staff know how to best accommodate them when booking their appointment. We were told that staff will always try and offer autistic patient appointments during quieter times at the practice.

We also saw evidence of a patient's preferred pronouns being noted in patient records.

From discussions with staff, it was clear that the practice work hard to uphold the rights of transgender patients. All staff have received internal training in order to best support and treat transgender patients and let them see their preferred clinician.

Of the 36 questionnaire respondents, 24 agreed that staff listened to them and answered their questions. One patient disagreed with this and 11 did not respond. 26 of the respondents also agreed that they were involved as much as they wanted to be in decisions about their care and that they were provided with enough information to understand the care being given to them. On both questions, the remaining 10 respondents did not provide an answer.

During our visit, the practice manager confirmed that there is currently no equality and diversity policy or discrimination policy in place at the practice. Staff should develop these policies as soon as possible and ensure both are read by all staff.

Listening and learning from feedback

We reviewed the complaints policy for the practice and noted that it contained out of date information, including details of the old practice manager. We informed staff that this document must be regularly reviewed and kept up to date going forward. The document did however comply with the NHS Putting Things Right procedure and provided guidance to patients and their carers should they wish to raise a complaint. The procedure outlined that the practice manager was responsible for managing complaints and we saw evidence that all complaints and compliments were kept on file. The practice website also provided information regarding making complaints and providing compliments.

Delivery of Safe and Effective Care

Safe Care

Managing risk and promoting health and safety
The practice was located within a two-storey building, with all surgeries and communal areas on the ground floor and administration rooms on the first floor. We found that the areas used by patients and staff were generally tidy and uncluttered.

Staff told us that the practice manager and deputy practice manager are responsible for receiving patient safety alerts and ensuring these are disseminated to the rest of the staff team. Any learning from patient safety incidents is shared in fortnightly staff meetings, or urgent meetings can my called if necessary.

We were informed by staff of the process for dealing with requests for home visits. When such calls are received, they are placed on a list for the on-duty doctor. Staff told us that there is one session per day dedicated to home visits and the visiting GP will carry out a risk assessment before each visit. Staff also noted that GPs still use personal protective equipment (PPE) when visiting vulnerable patients in nursing homes.

We were provided with the Business Continuity Plan for the practice. The plan contained relevant and up to date information, in line with local health board procedures, however we require the practice manager to ensure the plan contains a date for annual review.

As part of our inspection, we also reviewed practice risk assessments. We noted that the practice is yet to complete an environmental or IPC risk assessment. We raised this with staff and asked they carry out these risk assessments as soon as possible.

Staff showed us the significant events matrix in place at the practice. We found this to be very robust and detailed.

Infection prevention and control (IPC) and Decontamination
During our tour of the practice, we observed IPC to be managed well at the setting. The patient areas were visibly clean, and all areas had hard flooring. We saw evidence of hand hygiene facilities available for staff and patients. Soap was available in all patient toilets and there was alcohol gel available in communal area. All surgeries had appropriate handwashing facilities in place as well as ready access to a supply of personal protective equipment (PPE).

The practice continues to encourage to use of face masks. Signs on use of face masks were placed in communal areas, as well as information regarding the importance of using hand hygiene facilities correctly.

We reviewed the infection control policy for the practice. Although the policy covered all the relevant areas, the document was out of date, having been last reviewed in 2014. We raised this with the practice manager and asked this document be reviewed and updated as soon as possible.

There was an appointed infection prevention and control (IPC) lead at the practice. We saw evidence of monthly clinical waste checks carried out by this individual and completed online training. However, we recommend the IPC lead undertake the official 2-day IPC lead training course.

We saw evidence of appropriate waste management procedures in place at the practice. We reviewed copies of the monthly waste management audits for both clinical waste and sharps bins, however staff are yet to complete an IPC audit for the practice. We informed staff that this must be done as soon as possible. We showed nursing staff examples of completed IPC audits in order to assist them in completing one for the setting.

Our review of staff files provided evidence of up-to-date Hepatitis B vaccinations for all clinical staff at the practice.

Medicines management

Llynfi Surgery is a dispensing practice, however, the dispensary is located at their branch practice, Bryn Surgery. There are two dispensers working at the practice, who informed us of issues in gaining supply of certain medications. We were told that, although supply has improved, there are still difficulties obtaining HRT, Lamotrigine, Lamictal and penicillin. Staff informed us that the practice has good links with the local pharmacy who will assist in supplying these medications.

We reviewed the standard operating procedure in place which outlined the process for safe receipt and storage of boxed items. These are immediately unpacked and stored in a locked cupboard. Staff confirmed that no drugs are left out overnight and the dispensary is secured with three locked doors and a metal shutter.

Staff explained the processes in place for regularly checking stock levels in the dispensary. Monthly checks are carried out on all stock and any new stock is placed behind older stock on shelves. In the event of stock missing from the dispensary, staff told us that this would initially be investigated by the two dispensing staff members. If not resolved, this would be escalated to the practice manager.

We spoke to senior staff regarding the arrangements in place for ensuring prescription pads are securely stored. They informed us that these are either kept in a locked cupboard in reception or in printers in doctors' rooms. We were told that these rooms are locked at all times when not in use. Staff confirmed that, in the event a GP leaves the practice, their prescription pad would be shredded to prevent future use. We also saw evidence of a robust prescribing policy in place which covered processes for repeat prescriptions and the re-authorisation of certain prescriptions.

There was evidence of appropriate vaccine storage at the practice. We saw dedicated clinical fridges in place that we deemed appropriate for vaccine storage and evidence of twice daily temperature checked being carried out and documented.

Safeguarding children and safeguarding adults at risk

We saw evidence of separate policies in place for adult and child safeguarding. We reviewed both documents and noted that the adult policy did not include details of the local safeguarding team or a date for the policy to be reviewed. The child safeguarding policy was out of date, having not been reviewed since 2012. We spoke to senior staff about this and asked that both documents be reviewed and updated as soon as possible, ensuring all the relevant information is included in both.

We saw evidence of a process in place at the practice to easily identify children on the children protection register. Flags are placed on records of children on the child protection register and staff told us that these are reviewed at quarterly child protection meetings. Discussions with staff also indicated good knowledge of the process for removing the marker when it is considered the child is no longer at risk.

Our review of staff mandatory training informed us that not all staff had received the relevant level of safeguarding training. We require all staff, both clinical and non-clinical, to complete the relevant level of safeguarding training imminently.

Medical devices, equipment and diagnostic systems

According to staff, the practice manager was responsible for checking medical devices and equipment at the practice. All medical equipment checked appeared to be in good condition at the time of inspection.

We saw evidence of appropriate emergency drugs and equipment available at the practice. Rooms where emergency drugs oxygen cannisters are kept were clearly signposted and there was an automatic external defibrillator (AED) readily available

with in date adult and child pads. We also saw evidence that the AED was charged and contained in date batteries.

Staff informed of the robust process in place for the monitoring and replacement of resuscitation equipment and emergency drugs at the practice. Monthly checks are carried out and we saw evidence of these checks during our visit. It was also clear that staff have considered various other life-threatening emergencies that could present themselves during a visit to the practice. We saw that staff included emergency equipment and medicines that would help treat cardiac arrest, croup and asthma in with the emergency drugs and equipment.

Effective care

Safe and clinically effective care

Senior staff informed us that they are responsible for keeping up to date with best practice and national and professional guidance. The practice manager also told us that guidelines and examples of best practice are circulated to staff via email and team meetings.

We were told that any changes or updates to the National Institute for Health and Care Excellence (NICE) guidelines are discussed in clinical meetings. Information is then cascaded to other staff if relevant.

Information governance and communications technology

Staff informed us of the arrangements for data security at the practice. They confirmed the setting had a data protection officer who is appropriately trained. This service is provided by the local health board.

We saw evidence of a records management policy in place which outlined a clear process in place for handling sensitive and confidential data. Patients could access this via the practice website, however we recommend staff also display this in the waiting area, for those patients without digital access.

Record keeping

We reviewed a sample of 10 electronic patient medical records. These were secured against unauthorised access and easy to navigate. The records reviewed were generally legible and of a good quality. They all contained sufficient information regarding the individual recording each contact with the patient, the date of each appointment and the type of treatment given, and any decisions made during each appointment.

However, we raised with staff the need for improvements around linking the drugs prescribed to the clinical problem noted in patient records.

Quality of Management and Leadership

Governance, Leadership and Accountability
Llynfi Surgery is a partner lead, dispensing practice and part of the Bridgend North cluster group.

Staff informed us that one of the senior partners was responsible for clinical oversight for the practice.

Discussions with senior staff members confirmed that all staff are clear about their roles and responsibilities. We saw evidence of a clear management structure in place at the practice.

The practice manager provided us with information regarding the staff meetings taking place at the practice. We were told that the practice manager meets with the GP partners fortnightly. Information from this meeting is then cascaded down through the workforce via senior staff and line managers, during meetings held throughout the week by managers for both clinical and non-clinical staff. We saw evidence of meetings being minuted. All minutes reviewed had a good level of detail. The practice manager informed us that staff members can access minutes from all meetings through a shared computer drive.

Whilst reviewing practice policies, we discovered that several were not dated or contained dates for review. We require senior staff to update all practice policies, ensuring they are dated and contain a date for annual review. We also recommended that a template be added to the front page of each policy, in order to record the creation date, review date and any changes made.

We saw evidence of a communications protocol in place at the practice, however this had not been updated to include the use of Microsoft teams. We spoke to staff about this asked for it to be updated as soon as possible.

Workforce
During our inspection, we reviewed all staff files. We noted that members of the reception and admin teams did not have DBS checks on file. The practice manager confirmed that DBS checks were not routinely undertaken for any members of the reception or admin teams at the setting. We raised this as an immediate concern with senior staff. All members of staff without a DBS check must have the relevant checks undertaken immediately. Proof of DBS checks for all staff must then be kept on record by the practice manager.

Our review of staff records also highlighted a lack of evidence for CPR training for staff. The practice manager informed us that the Advanced Paramedic Practitioner at the practice has provided training in CPR for all staff, however no certificates were provided. We also raised this as an immediate concern with practice staff. The practice manager must ensure that all staff receive CPR training and that evidence of this is kept in staff files.

We saw evidence of a training matrix in place to monitor staff compliance with mandatory training. The practice manager also informed us that staff are encouraged to do additional training and that senior staff are proactive in identifying their own training needs. We were informed that training needs for all other staff are identified by line manager through appraisals and team meetings.

The practice manager confirmed that staff had not received equality, diversity, and inclusion training. Staff must complete this training and a record kept in staff files.

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 identified			

Appendix B - Immediate improvement plan

Service: Llynfi Surgery

Date of inspection: 23/01/2023

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	Standard/ Regulation	Service action	Responsible officer	Timescale
The practice must ensure that pre-employment checks for all staff include a DBS check appropriate to their roles	7.1 Workforce	Many of our staff have been with us a number of years and did not have DBS checks in their records. We have not routinely carried out DBS checks on new reception and admin team members, To rectify this the following will happen. We have arranged for the company DDC to complete DBS checks on all reception and admin staff who have not had DBS checks. This process has started and evidence of this can be provided if needed	Paula Jones	30/01/2023

		A spreadsheet has been set up, which has the DBS numbers for all reception, admin and clinical staff, as requested. We now have a policy in place to ensure new staff starting have DBS checks and their DBS number will be added to the spreadsheet once complete.		
The practice manager must ensure that all staff receive CPR training and that evidence of this is kept in staff files.	7.1 Workforce	Staff have had CPR training but with our Advanced paramedic practitioner (APP) and there was a question about his qualification to teach staff CPR. It was recommended our admin and reception staff have BLS yearly when previously we believed this to be every 3 years. To rectify the above we will be doing the following. Our APP will be completing the Basic Life support instructor (BLSi)course with the Resuscitation Council UK on 27/01/2023.	Paula Jones	30/01/2023

On completion he will gain a training certificate which will be valid for three years.

After completion of the course, CPR training will be carried out over the 2 weeks commencing on 30/01/2023. The entire practice will receive training over this period.

Our APP will be able to provide during the training a sign off sheet of the competencies in BLS and will also include how to manage an emergency in the practice, where our emergency equipment is and how to use the red button on emis.

He will provide a certificate to confirm the individual passed all the competencies.

5 doctors and our paramedic all have up to date CPR certificates (these can be provided if needed) and our rotas have been checked

		and until the CPR training has been complete there will always be someone on site who has been trained. A Policy is to be written outlining the frequency of CPR training, Including CPR training in our induction of new starters and the training requirements and the qualifications of our APP.		

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: Jenna Tuthill

Date of inspection: 23/01/2023

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
Staff must carry out both an environmental risk assessment and IPC risk assessment for the setting as soon as possible.	Standard 2.1 Managing Risk and Promoting Health and Safety	An environmental risk assessment has been carried out on 30/01/2023. The IPC risk assessment is scheduled to be completed by 31/03/23	Paula Jones/Natalie Treharne	31/03/2023
Staff must ensure that clear links are noted between drugs prescribed and the clinical problem in patient records.	Standard 2.1 Managing Risk and Promoting Health and Safety	All clinical staff reminded when adding new medication to ensure appropriate coding for the reason in notes.	Dr Rachel Cribb	27/01/2023

Staff must ensure the Business Continuity Plan is dated and also contains a date for annual review	Standard 2.1 Managing Risk and Promoting Health and Safety	The Business Continuity Plan has now been dated, with a date for the next annual review included	Paula Jones	26/01/22023
Staff must review the complaints policy for the practice, ensuring the document contains up to date information	Standard 6.3 Listening and Learning from Feedback	The complaints policy has been reviewed ensuring that it now includes up to date information	Paula Jones	14/03/2023
All staff must complete equality and diversity training as soon as possible	Standard 7.1 Workforce	Equality and diversity training has been arranged for PT4L afternoon on the 28/03/2023	Paula Jones	28/03/2023
The practice manager must develop and implement an equality and diversity and discrimination policy for the practice imminently	Standard 3.4 Information Governance and Communications Technology	An equality, diversity and discrimination policy has now been developed and implemented	Paula Jones	26/01/2023
The practice manager and senior staff must conduct a review of all practice policies to ensure they are up to date and contain a review	Standard 3.4 Information Governance and Communications Technology	All policies will be reviewed and updated by the 30/04/2023. A top sheet will be added to all policies with date reviewed and date of next review.	Paula Jones	30/04/2023

date – all policies should be reviewed annually.				
The practice manager must ensure that a triage policy and consent policy are developed – extract information in the practice Care Navigation SOP and make reference to this document in both policies.	Standard 3.4 Information Governance and Communications Technology	Work has begun on developing a triage and consent policy by extracting information from the Care Navigation SOP. This will be completed by the 31/03/2023	Paula Jones	31/03/2023
We informed senior staff that the IPC lead for the practice should undertake the relevant IPC lead training course	Standard 7.1 Workforce	IPC training to be sourced and completed by 30/04/2023	Paula Jones/Natalie Treharne	30/04/2023
We require all staff, both clinical and non-clinical, to complete the relevant level of safeguarding training imminently	Standard 7.1 Workforce / Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk	All staff have completed level 1 Safeguarding training. Practice Managers to complete safeguarding level 2 in PT4L 28/03/2023	Paula Jones	28/03/2023
We informed senior staff that the communication protocols for the practice should be updated in	Standard 3.4 Information Governance and	The communication policy has been updated to include Microsoft Teams	Paula Jones	10/03/2023

order to accommodate the use of Microsoft Teams	Communications Technology			
Staff should ensure the records management policy is displayed in the practice waiting room for parents, rather than just on the practice website.	Standard 4.2 Patient Information	The Records management Policy has now been displayed in our waiting room	Paula Jones	01/02/2023
The practice manager must ensure that both the adult and child safeguarding policies are reviewed and updated to include all relevant information, as well as dates for annual reviews.	Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk	Both adult and child safeguarding policies had been reviewed. A date has now been included for the next annual review	Paula Jones	10/03/2023

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): Paula Jones

Job role: Practice Manager

Date: 09/03/2023