Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Follow-up Inspection (Announced)

Llanyravon Surgery / Aneurin Bevan University Health Board

Inspection date: 24 June 2019

Publication date: 25 September 2019

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Digital ISBN 978-1-83933-227-2

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

Our purpose

To check that people in Wales receive good quality healthcare

Our values

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

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

Our priorities

Through our work we aim to:

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

1. What we did

Healthcare Inspectorate Wales (HIW) completed an announced follow-up inspection of Llanyravon Surgery, Cwmbran, Torfaen, NP44 8HW, within Aneurin Bevan University Health Board on 24 June 2019.

Our team, for the inspection comprised of two HIW Inspectors, one of whom led the inspection, GP and practice manager peer reviewers and a lay reviewer.

Further details about how we conduct follow-up inspections can be found in Section 5.

2. Summary of our inspection

We found evidence that the service made efforts to provide safe and effective care to patients. However, we found that the practice was not fully compliant with the Health and Care standards in all areas.

This is what we found the service did well:

- The majority of patients who provided comments told us they were happy with the service being provided at the practice
- During our visit we observed staff at the practice treating patients in a polite, professional and dignified manner
- The practice was being well run by the practice manager who took a lead role in the managing of all non-clinical activities
- Staff we spoke with were happy working at the practice and felt fully supported in carrying out their relevant roles
- It was clearly evident from our visit that the practice team were determined and committed to provide a quality services to patients
- We saw evidence of good care plans relating to patients requiring palliative care, dementia and asthma support
- A patient focussed approach was clearly demonstrated.

This is what we recommend the service could improve:

- Implement a formal process to enable in house second opinions on GP records and peer reviews of referral outcomes
- Develop and formalise systems to clearly demonstrate the activity being undertaken by staff to promote safe and effective care including regular audits of clinical records
- Quality of the detail documented in some of the patient records reviewed
- A documented risk register at the practice that captures all risks, as well as the mitigating actions being taken by the practice.

3. What we found

Background of the service

Llanyravon Surgery currently provides services to approximately 4076 patients in the Pontrhydrun, Pontnewydd, Croesyceiliog, Northville, Southville, Llanyravon, Oakfield and Llantarnam areas of Torfaen. The practice forms part of GP services provided within the area served by Aneurin Bevan University Health Board.

The practice employs a staff team which includes a GP, one advanced nurse practitioner, one specialist nurse, one practice nurse, two healthcare support workers and a team of receptionists and administration staff.

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

The practice provides a range of services, including:

- General medical services
- Child/baby clinic
- COPD[1] clinic
- Asthma clinic
- CHD clinic
- Cervical screening
- Contraception advice
- Diabetes clinic
- Ear syringing

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

- Smoking cessation
- Social prescribing
- Social Services
- On-site counselling
- Phlebotomy
- Travel vaccinations
- Weight management
- Non NHS service (for example completing insurance claim forms and vaccination certificates).

HIW last inspected Llanyravon Surgery on 20 March 2018. The key areas for improvement we identified during the last inspection included the following:

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

The purpose of this inspection was to follow-up on the above improvements identified at the last inspection.

Quality of patient experience

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

The majority of patients who provided comments told us they were happy with the service being provided at the practice.

During our visit we observed staff at the practice treating patients in a polite, professional and dignified manner.

Efforts were being made to provide patients with sufficient information on the services provided by the practices, as well as the other services and support available. However, we did identify that improvement was needed in ensuring that patients' records were being routinely updated when information was being provided to patients during consultations.

We also identified issues around the lack of a formal process in place to enable in house second opinions on GP records and peer reviews of referral outcomes.

What improvements we identified in our previous report

Areas for improvement identified at last inspection included the following:

- The practice was required to provide HIW with details of the action taken to increase staff awareness of the role of the identified Carers Champion
- The practice was required to provide HIW with details of the action taken to include further details within the chaperone policy around what is expected of staff whilst carrying out chaperone duties
- The practice was required to provide HIW with details of the action taken to:

  a) ensure patients sign a consent form to demonstrate valid patient consent has been obtained as necessary

b) ensure a record was made within patients' medical records when written advice is provided to patients.

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

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

  a) formal systems for in-house second opinions

  b) formal system for peer review of outcomes of patient referrals and GP patient referral patterns/rates.

- The practice was required to provide HIW with details of the actions taken to re-establish a patient participation group.

What actions the service said they would take

The service committed to take the following actions in their improvement plan dated 26 April 2018:

- All staff to be reminded of who is the Carers Champion

- All staff undertook chaperone training prior to previous inspection and are therefore aware of their roles in relation to their duties. Policy will be amended to include this

- Practice have created a form for patients to sign prior to any procedure. However, as the practice is attempting to move away from the use of paper, the previous form was discarded and instead verbal consent is recorded on electronic patient records

- Information is available in Welsh at the practice and on the practice website. However, the practice will endeavour to display more Welsh information as and when it becomes available

- Formal systems for in house second opinions and review of outcomes relating to patient referrals is difficult for the practice due to there only being one Doctor. However, the practice is in the process of securing / interviewing for a salaried GP and this will then be possible.

What we found on follow-up

The staff we spoke to during our inspection were aware of the Carers Champion role, as well as who the designated Carers Champions were at the practice. There was also a sign in the waiting room area to notify patients as to who the Carers Champions were.

There was a written policy on the use of chaperones and 15 staff from the practice had attended relevant training. Information relating to the chaperone policy was available in the waiting room area. Whilst a policy was in place, it did not include specific details in regards to the staff role and expectations. During discussion with a senior member of staff, we were informed that as staff had undertaken the relevant training, it was felt that the specific detail in relation to expectations of staff was not required to be included within the policy. Therefore, there were no plans to amend the policy.

A consent policy was in place setting out arrangements for obtaining valid patient consent. The practice was no longer using written consent forms to record patient consent. The EMIS patient records systems being used has a relevant section to confirm that patient consent has been obtained.

In some of the patient medical records reviewed there was limited evidence to indicate that information had been provided to patients in relation to their condition, any investigations or their care management options.

The practice information leaflet and the majority of other information leaflets within the waiting room area were available in English and Welsh. Staff told us that not many of their patients requested to communicate in Welsh. However, there are two Welsh speaking members of staff, one of whom is a GP, should patients wish to converse in Welsh.

Information available on the practice website was available in a variety of different languages. Staff told us that should there be occasions where patients wish to converse in other languages, they would access the telephone translation services.

The practice had a hearing loop system available for patients, which could be used to help communication between practice staff and patients with hearing difficulties. Braille information could be made available for patients on request. Staff told us that patients with any additional communication needs predominantly visited the practice with a relative or carer.

There was no formal system at the practice for in house second opinions, nor was there a formal system to review the outcomes of patient referrals. Senior

staff told us that at the practice only had one permanent GP it was difficult for formal review processes to be implemented.

The practice had been unable to re-establish the Patient Participation Group (PPG). The previous group disbanded due to a lack of commitment. There was a notice in the waiting room seeking interest from patients in attempt to re-establish the group. At the time of our visit, there has been no interest from patients. However, the practice had taken steps in attempting to set up a virtual PPG on the practice website in an attempt to get regular feedback on the services being provided.

Prior to our inspection, we invited the practice to distribute HIW questionnaires to patients to obtain views on the services provided. We also spoke to a number of patients attending the practice on the day of our visit to discuss their views and experiences. In total we received 28 completed questionnaires. The majority of patients that completed a questionnaire were long term patients at the practice (those that had been a patient for more than two years).

Patients were asked in the questionnaire to rate the service provided by Llanyravon GP practice. Responses were positive; the majority of patients rates the service as 'excellent' or 'very good'. Patient comments included:

> *“Service very good especially as staff are coping with pressures”*
>
> *"I am very satisfied with the help I get from this surgery. Long may it continue with the staff they have there now"*
>
> *"I have nothing but admiration for the nurses and receptionist, they do a great job"*

Patients were asked in the questionnaires how the GP practice could improve the service it provides. Comments suggested for improvement included:

> *"Greater flexibility of appointments evening or weekends"*
>
> *"The surgery could do with another permanent doctor"*
>
> *"Improve the computer booking in the hall. It can't be trusted to book you in"*

Staying healthy

There was a large selection of information available in the patient waiting room which included details relating to health promotion and support groups available.

Much of this was in the form of leaflets, which patients could take home to read and keep for future reference. The information available included guidance relating to infection and virus prevention, vaccinations, smoking cessation and cancer screening. Whilst the quantity of information available was good, it was recommended that the practice should consider displaying the information in themes, where possible, to enable patients to identify the information most appropriate to them more easily.

Within the waiting room there was also an information hub poster which included QR code links to various sources of useful information for patients which could be accessed by scanning the relevant code with a mobile phone. The information available included details on local services, vaccinations and self-help guides and healthy lifestyle advice.

Community based services regularly work from the practice. These include, social services, mental health support and health visitors. Staff at the practice told that us that there are good relationships and links with these services.

The practice has two carers champions and there was a notice available in the waiting room informing patients who the staff members assigned were. As described above, all staff we spoke to were aware of who the carers champions at the practice were. Information relating to carers was flagged on the relevant patients' record.

There was a self-service blood pressure monitor available within the reception area for patients to use. This meant that patients could check their own blood pressure prior to their appointment and subsequently share the results with the nurse or GP, so that further investigations/treatment could be arranged as necessary.

Clinical meetings are held regularly and discussions during these meetings include the future development of the practice including potential implementation of additional services to be provided. The practice is looking to develop the

provision of INR[2], B12[3] and Nexplanon[4]. The practice intend to include these plans on their annual Practice Development Plan[5].

Improvement needed

The practice should consider organising the information contained within the waiting room area into themes, to assist patients in identifying the information most appropriate to them.

Dignified care

All patients we spoke to during our visit and the patients who completed the questionnaires told us that they had been treated with dignity and respect when visiting the practice. During our inspection, we saw staff speaking to patients in a polite, professional and dignified manner.

Reception staff told us that on the occasions where patients wanted a more private conversation when arriving at the practice, they were taken to a private room away from the main reception area to speak.

Consultation and treatment rooms within the practice were located down the corridor away from the waiting area. This helped reduce the possibility of consultations being overheard by other people. The doors to the consultation rooms were closed when staff were with patients and there were also 'do not

[2] The international normalized ratio (INR) is calculated from a prothrombin time (PT) test which is used to help detect and diagnose a bleeding disorder or excessive disorder. It is used to monitor how well the blood thinning medication is working to prevent blood clots.

[3] Treatment of B12 deficiency generally includes monthly injections of vitamin B12.

[4] Nexplanon (etonogestrel) is a hormone implant that prevents ovulation (the release of an egg from an ovary).

[5] A review of local need and the provision of services by the practice to create a Practice Development Plan with priorities for action

disturb' signs on the doors. This meant that staff were taking appropriate steps to maintain patients' privacy and dignity during consultations.

However, during our tour of the practice, we did identify that not all patient consultation / treatment rooms had curtains around the couches.

Information was available advising patients that they could request a chaperone be present. The use of chaperones aims to protect patients and healthcare staff. There were 15 practice staff that had undertaken training on the role and expectations of a chaperone. Whilst there was a written policy in place, it did not include specific details in regards to the staff role and expectations. As detailed previously, during discussions with a senior member of staff, we were informed that as staff had undertaken the relevant training, it was felt that the policy did not need to include the specific responsibilities of chaperones. Therefore, there were no plans to update the policy.

Improvement needed

The practice is required to provide HIW with details of the action taken to ensure all patient consultation / treatment rooms have curtains available around the couches within the room.

Patient information

The waiting room area contained a lot of information in the form of leaflets and posters in relation to other services available and as well advice on issues such as smoking cessation and vaccinations. There were also folders available with copies of relevant practice information which included the practice information booklet, complaints procedures, GDPR guidance and other relevant practice policies and procedures.

As previously detailed, there was an information hub poster available within the waiting room which contained QR codes to enable patients to access useful information. The information links available via the QR codes included the practice website, practice policies, self-help guides, chronic disease and vaccination information, as well as information relating to other local services and access to benefits.

A consent policy was in place which set out the arrangements for obtaining valid patient consent. The practice was no longer using a consent form for patients to sign to confirm consent had been obtained. Staff were completing the relevant section on the EMIS patient record system to confirm that verbal consent had been obtained from the patient.

However, the consent policy specified that written consent needed to be obtained by staff prior to any minor surgery procedure undertaken. This issue was discussed with senior staff and it was subsequently agreed that the policy needed to be amended to reflect the practice process for obtaining and recording consent electronically.

During the previous inspection, it was highlighted that patient medical records did not always demonstrate when information had been provided to patients during consultations. During the follow up inspection, it was again identified as part of the review of patient medical records that there was limited evidence to indicate that patients had been provided with information in relation to their conditions, investigations or management options during their consultation. Therefore, arrangements should be made to ensure that when information and/or advice is provided to patients, it is recorded.

Improvement needed

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

- update the consent policy
- ensure a record is made within patients' medical records when information / advice is provided to patients.

Communicating effectively

The majority of patients who completed a questionnaire told us that they were ‘always’ able to speak to staff in their preferred language.

All of the patients who completed a questionnaire felt that things are always explained to them during their appointment in a way that they can understand and they also told us that they are involved as much as they wanted to be in decisions made about their care.

The practice's website included general NHS information in over 20 languages.

The majority of information within the patient waiting room area was bilingual. We were also told that there were two members of staff at the practice that spoke Welsh, one of whom is the GP. For patients wishing to communicate in any other languages, staff would contact translation services for assistance. However, we were told that this was rarely required.

As previously stated, there was a hearing loop available at the practice and we were told that information could be made available in Braille on request. Staff told

us that patients with additional communication needs predominantly attended the practice with a carer or relative.

The practice had a self-check-in (touch screen) machine in the main foyer that patients could use to confirm that they had arrived for their appointment. This machine offered a choice of language options for patients to choose from. However, discussions with reception staff and feedback from patients highlighted that there was a reluctance from some patients in using the machine. This was felt to be due to a lack of understanding of how to use the equipment, as well as a lack of confidence in the machine. Staff told us that there were going to be further attempts to encourage more patients to use the machine.

Arrangements were described for ensuring that incoming correspondence / communication to the practice had been read and acted upon. There was a correspondence workflow process being followed which was predominantly coordinated by the Assistant Practice Manager. Both the Practice Manager and Assistant Practice Manager had undertaken external training on workflow. The process involves input from relevant practice staff at key intervals in reviewing and taking actions following correspondence received. However, it was highlighted that there was no workflow policy in place to underpin the process being followed. A policy needs to be implemented outlining the workflow arrangements, which also includes a list of documents that need to be sent to the GP for review/action when they are received.

Improvement needed

The practice is required to provide HIW with details of the action taken to implement a workflow policy.

Timely care

The majority of the patients who completed the questionnaire told us that they were ‘very satisfied’ with the hours that the practice was open. The majority of the patients also said that it was ‘very easy’ or ‘fairly easy’ to get an appointment when they needed one.

When asked to describe their overall experience of making an appointment almost all of the patients who completed a questionnaire described their experience as ‘very good’ or ‘good’.

The practice opened between 8:30am to 6:30pm, Monday to Friday. A mixture of pre-bookable (routine) and on the day (emergency appointments) were offered.

Appointments could be made over telephone, by visiting the practice or by using My Health Online[6].

There was only one permanent GP at the practice, with over 4000 patients. Senior staff told us that there had been numerous attempts to recruit an additional GP, but unfortunately they had been unsuccessful to date. Patients usually had to book one week in advance for a GP appointment. Online booking allowed patients to book up to four weeks in advance. On the day appointment phone calls received are initially triaged by reception staff and signposted.

Emergency appointments were initially seen by an Advanced Nurse Practitioner (ANP). Following this assessment, the patient would subsequently be referred to the GP or another service if required.

The practice also participated in the Choose Pharmacy[7] initiative, where patients would be signposted, where deemed appropriate, to a local pharmacist for advice and treatment on a range of minor ailments.

The above arrangements have been implemented in an attempt to reduce the demand on the GP, whilst also ensuring the patients are seen by an appropriate healthcare professional depending on their care and treatment needs.

As highlighted in the previous inspection, there was still no formal processes in place for in house second opinions or for the peer review of the outcomes of patient referrals. This would be considered a useful element of a practices' governance arrangements. There was also no peer review of individual GP patient referral patterns/rates, which is regarded as good practice within primary care.

Whilst we appreciate the challenges presented in implementing the systems outlined above for single GP practices. The practice should consider methods in

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

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

which formal peer review systems can be implemented, for example linking in with other practices from within the same GP cluster[8] to allow for peer review.

Improvement needed

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

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

Individual care

Planning care to promote independence

The practice was located in a purpose built building and all patient consulting and treatment rooms were located on the ground floor. This arrangement together with the level access to the building helps with mobility difficulties entering and moving around the practice safely. There is also a blue button on the main entrance door, which patients can use if they require assistance entering the building. However, we did observe some elderly patients with mobility issues struggling with the main doors to the practice.

Senior staff told us that funding has been granted for new automatic doors for the practice. There were no set timescales for the new doors. However, we were informed that the funding had to be spent by March 2020.

New patients to the practice were required to complete a questionnaire and attend an appointment with the practice Healthcare Support Worker. This was aimed at ensuring suitable arrangements and support were put in place to meet the care and treatment needs for the patient.

[8] A Cluster is a grouping of GPs working with other health and care professionals to plan and provide services locally.

As described previously, a range of health promotion material was available both at the practice and on the practice website. This aimed to assist patients take care of their own health and wellbeing.

Patient care plans were being completed by the nurses. We saw evidence of good care plans relating to patients requiring palliative care, dementia and asthma support.

The patient management register identified the patients that required additional support. Arrangements were in place to meet the needs of patients with additional needs. Senior staff confirmed that annual health reviews for patients with learning disabilities took place.

People's rights

There were written policies in place relating to equal opportunities and ethnic monitoring. Our findings throughout this section (Quality of patient experience) indicate that the practice was aware of its responsibilities around people's rights. During our visit we observed patients being treated with respect and efforts made by staff to protect their privacy. We also saw evidence of the efforts made to provide services to patients, taking into account their individual needs, for instance staff taking patients to a private room for discussions when requested.

Listening and learning from feedback

The practice had a procedure in place for patients and their carers/relatives to raise concerns about the services they receive. The procedure was in line with the current arrangements for dealing with concerns (complaints) about NHS care and treatment and treatment in Wales, known as Putting Things Right[9]. The complaints procedure outlined the process to follow and included timescales, as

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

well as references to the Community Health Council[10] and the Public Services Ombudsman for Wales[11].

A copy of the complaints procedure was available in the waiting room in hard copy and on the QR board. The procedure was also available on the practice website.

All complaints received by the practice are dealt with by the Practice Manager and kept in a folder with all complaint correspondence sent and received. Concerns are discussed at staff meetings and patients are provided with feedback on any concerns received. There was also an annual report available which detailed complaints figures and themes.

During discussions with the practice manager, we were given an example of one complex concern that is being dealt with. Due to the complexity of the concern we were told that advice and support was requested from the health board. However, the practice manager informed us that the health board had not provided timely input into the matter.

A suggestions box was available in the waiting room area for patients to provide any feedback on their experiences. However, reception staff told us that patients would predominantly speak to staff in relation to any suggestions or issues they may have, which are then fed back to senior staff at the practice as and when required. The practice website also offers patients and carers the opportunity to provide comments and suggestions as to how the service being provided can be improved.

There was a whistle-blowing policy in place and all staff we spoke to informed us that they would feel able and comfortable in raising relevant concerns if required.

As previously mentioned, there was no Patient Participation Group (PPG) active at the practice. There was a notice in the patient waiting room advertising roles

[10] http://www.wales.nhs.uk/sitesplus/899/page/71619

[11] Public Services Ombudsman for Wales has the legal powers to look into complaints about public services and independent care providers in Wales.

on the group, however there has been no interest thus far. However, the practice has also taken steps in attempting to set up a virtual PPG on the practices' website.

The practice had previously carried out a patient survey during May/June 2018, offering patients the opportunity to provide feedback via questionnaires on their experiences at the practice. In total, there were 22 responses received from 50 questionnaires that were handed out. The results were analysed subsequently published on the website and displayed in the practice waiting room.

Given the pressure the practice had been under in recent months, there had been no patient survey arranged, as yet, this year. However, we were told by staff that there were plans to undertake a similar exercise to gather up to date patient and care views on the services being provided.

Improvement needed

The practice is required to provide HIW with details of the action taken to ensure regular patient surveys are undertaken.

Delivery of safe and effective care

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

Overall we found that patients were being provided with safe and effective care. However, we did identify that some improvement was required to develop and formalise systems to clearly demonstrate the activity being undertaken by staff to promote safe and effective care.

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

There was no overarching risk register in place at the practice that captured all risks, as well as the mitigating actions being taken by the practice.

Overall record keeping within the patient medical records was of a satisfactory standard. However, we did identify some issues which require improvement which related to inconsistency in the quality of the detail documented in some of the patient records reviewed.

What improvements we identified in our previous report

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

  a) implement an agreed formulary;

  b) regularly review the prescribing system;

  c) ensure patients' medical records contain sufficient details around removing medication from the repeat prescribing list;

  d) implement a formal system to identify training required by team members relating to prescribing.

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

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

  a) ensure that serious incidents are reported to the health board as appropriate and in accordance with local requirements;

  b) ensure that new clinical guidelines are discussed and agree on how these may be implemented within the practice;

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

  a) ensure patients' medical records clearly reflect where consultations have taken place;

  b) promote the consistent use of Read coding;

  c) ensure an effective audit system of patient medical records is in place.

What actions the service said they would take

The service committed to take the following actions in their improvement plan:

- Fire assessment now carried out - recommendations to be carried out within a month are to replace one door on 1st floor and to carry out a five year test on electrics

- The practice formulary agreed by the Local Health Board for Medicines Management

- The practice will introduce medication audits which will be carried out quarterly

- Checks on medication records in relation to removing medication from medication lists is done every six months. However, the practice will review this

- The practice has a staff training matrix which includes training on prescribing for appropriate staff

- All staff have received a written notification relating to who the safeguarding lead is, although they had been informed and signed the document in the past

- Practice will look to report serious incidents via alternative method other than Yellow Card Reporting[12]. This is done alongside reporting of our significant Events which are done on an annual basis in line with the Health Board directions

- The practice has arranged to carry out clinical meetings to discuss new clinical guidelines and how these maybe implemented within the practice

- The clinical staff have started the process of ensuring patient medical records clearly reflect where consultations have taken place, since it was suggest during the previous HIW inspection

- Meetings arranged to discuss the consistent use of Read coding and all staff have been provided with a list of regular codes.

What we found on follow-up

A fire assessment was carried out by an external third party on 23 March 2018. We were told by the practice manager that following on from the assessment there were a number of queries raised around the accuracy of the report which was received. Subsequently, an amended report was received which did not reflect some of the issues raised by the Fire Officer at the visit, for example the office door on the first floor that needed to be replaced.

Due to the queries around this requirement, the practice arranged for another Fire Officer from a different organisation to attend the practice for a second opinion. Following this visit, the Fire Office also highlighted issues with regards to the previous fire assessment report which was produced. It was identified that the report findings and actions were more pertinent to a dwelling (where someone would sleep overnight), which means that some of the doors at the practice would not reach the required standard. However, for a surgery, the doors which are fitted would allow for evacuation within the required time limit. The practice

[12] http://www.wales.nhs.uk/ourservices/directory/NationalProgrammesandServices/372

manager confirmed that the other outstanding recommendation highlighted during the previously fire assessment have now been addressed. Evidence was provided to demonstrate that the five year check on electrics was carried out in May 2019.

A local and National formulary was available for reference. Also, NICE[13] and health board formularies are followed.

There was no evidence seen during our inspection to demonstrate that formal reviews or audits of the prescribing systems were being carried out by the practice.

A staff training matrix was available. However, the dates specific training was undertaken by staff was not included on the document. Each staff member had individual files which included hard copies of training certificates. We were also told by senior staff that the practice was now using Croner which was an internet training package which monitored and logged training requirements for staff. This meant that when training was due, reminder correspondence was sent to the individual staff member and the practice manager.

We were told by senior staff at the practice that the GP and other relevant staff within the practice had received adequate training relating to prescribing.

During the review of medication changes documented in the patients' notes, we noted that that changes to patient medication prescriptions following medication reviews and from hospital correspondence, were being carried out predominantly by the Assistant Practice Manager. On occasion the changes were also made by the Advanced Nurse Practitioner or the GP. It was highlighted by our reviewer that there did not appear to be method to check who was responsible for making the relevant changes to the patients' medication as all changes which were being made were logged under the GPs name. This would mean that there was no audit trail.

This issue was raised during the feedback meeting as an issue which needed to be addressed. However, we were told by senior staff that there was a method

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

that would allow an individual to access detail that indicated which member of staff made the changes.

The staff we spoke to during our inspection were aware of the role of the safeguarding lead, as well as who the safeguarding lead was at the practice.

There were inconsistencies in regards to the reporting of significant events / incidents to the health board. We were told by senior staff that issues relating to significant incidents and patient safety incidents were discussed in staff meetings to ensure that learning was shared where appropriate. An issue was identified whereby a patient with cancer (in remission) was referred in April to Velindre. In June the patient returned to the practice and it was at this point that it was identified that the patient had not been seen by the hospital following the GP referral. The GP subsequently phoned the registrar to chase up the patient's hospital appointment. However, there was no serious incident reported by the practice to the health board to highlight the fact that the patient had not been seen by the hospital within the required timescales.

We were told that regular discussions are held in staff meetings to discuss clinical guidelines and how the required changes/improvements can be incorporated at the practice.

As part of our review of clinical records it was highlighted that not all patient consultations were being recorded. Documentation reviewed was inconsistent and needs to be strengthened to ensure that all patient consultations face to face and via telephone are routinely being recorded within patient medical records.

Staff dealing with the coding at the practice are adequately trained and experienced. However, there was no evidence of any checks or reviews of the quality of coding to identify any issues or inconsistencies. We were told by the lead GP that he does not do any coding.

There was limited evidence to demonstrate that audits were being completed of patient medication records. As previously detailed, the practice should consider methods in which formal audits reviews can be implemented to identify any issues and/or learning.

Safe care

Managing risk and promoting health and safety

The reception desk, waiting area, consulting rooms and treatment rooms were all located on the ground floor to the practice. There was level access to the main

entrance to the practice, and a blue button for patients to use near the main door to request assistance from staff.

All patients that completed a questionnaire felt that it was ‘very easy’ or ‘fairly easy’ to get into the practice building. However, we did observe some elderly patients with mobility issues struggling to open the main entrance doors. As previously detailed, senior practice staff confirmed that funding has been granted for new automatic doors to be installed at the practice, which it is hoped will be installed before March 2020.

During our tour of the practice, we saw that areas used by staff and patients were clean and free from any unnecessary clutter. Also, the boiler room which was found to be storing cleaning equipment during our previous inspection, was free from any equipment which could have posed a fire hazard.

As part of our tour of the practice it was identified that one of the lights near the entrance to the practice appeared to have dropped on the one side. This issue was raised with the practice manager who informed us that a patient at the practice had also raised a concern about the same light recently. The light was subsequently checked and deemed to pose no risk to patients or staff.

Fire safety equipment was located around the practice. Labels on fire extinguishers indicated that they have been serviced in June 2019 to ensure they were working. As previously detailed, a fire safety assessment was undertaken in March 2018. The subsequent actions following this assessment have been addressed.

Work station reviews and risk assessments relating to fire, health and safety and disabilities were completed in 2018 and a legionella assessment was completed in March 2019. However, we identified that these assessment needed to be reviewed. Assessments undertaken need to be reviewed annually to ensure that there are no amendments required.

The main practice risks were discussed with senior staff. The main risk related to recruitment, as the practice had been unable to recruit an additional GP to work at the practice. The practice does have two regular locums who cover surgeries when required.

It was highlighted that there was not an overarching risk register available that detailed all of the practices' risks. We were told that risks that occur are dealt with as and when required. The practice needs to develop a risk register which captures and monitors all potential risks, including the mitigating actions taken by the practice.

Staff confirmed that there was a practice contingency plan in place should any issues occur which effect the ability of the practice to deliver the relevant services.

Improvement needed

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

- ensure that all light fittings at the practice are safely secured
- ensure risk assessments which are completed are reviewed regularly
- ensure a risk register is implemented which details all practice risks and mitigating actions taken
- ensure that serious incidents and events are reported to the health board as appropriate in accordance with local requirements.

Infection prevention and control

There were no concerns given by patients over the cleanliness of the GP practice; the majority of the patients that completed a questionnaire felt that, in their opinion, the GP practice was ‘very clean’.

The treatment room and consulting rooms appeared visibly clean. Hand washing and drying facilities were available within these rooms to help reduce cross infection. We saw that personal protective equipment (PPE) were available to clinical staff to reduce cross infections.

An infection control policy was in place, which had last been updated in November 2018. An infection control audit was completed in May 2019.

There was also a separate policy for waste management. All staff had access to these policies via the practice shared drive.

Staff immunisation records are held on their individual files. Hepatitis B immunisation checks for relevant staff were checked as part of the employment process. We selected a random sample of relevant staff files, all of whom had the relevant medical certificate confirming immunisation status.

Medicines management

As previously detailed, a local and National formulary was available for reference. Also, NICE and health board formularies were being followed.

There was no formal system in place at the practice to regularly review the prescribing system. A formal system would help to identify any issues with a view of making improvements that promote safe and effective prescribing of medications.

As detailed previously, a potential issue was identified during our review of patient clinical records, whereby we were unable to establish which member of staff had made the required medication changes for patients. During discussions, the GP was also unable to trace who made some of the medication changes. During our feedback meeting with senior staff, we were reassured that it was possible to identify the specific staff member that action the changes to medication. However, given the uncertainty experienced when reviewing the records with the GP, further assurances will be required from the practice in relation to the system.

Information relating to repeat prescriptions for patients was available on the practice information leaflet in hard copy within the waiting room and electronic version via the QR board and the practice website.

As previously outlined, the practice was now using the Croner training package to monitor training requirements for staff within the practice. We were told that the lead GP and other relevant staff within the practice had received adequate training relating to prescribing.

During our review of clinical records, it was identified that a medication script was completed by a staff member at the practice with instruction to prescribe 1000mls of Oramorph[14] instead of 100mls. This issue was identified by the pharmacist who subsequently contacted the practice to query. The script was subsequently amended. Following identification of this issue, the practice appropriately completed a Significant Event analysis form. The practice must ensure that any lesson learned identified are shared with staff internally and via the GP cluster.

[14] Oramorph is a liquid form of morphine, which is often used as a pain killer, in small doses oramorph is used for the relief of long term or chronic breathlessness.

Improvement needed

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

- regularly review the prescribing system
- ensure an adequate, auditable system is in place for logging and tracking changes made to patient medication by staff. All clinical staff must be trained in the use of this system.
- ensure lessons learned from Serious Events are shared internally and externally.

Safeguarding children and adults at risk

There were written procedures available in regards to safeguarding children and vulnerable adults.

Staff we spoke to were aware of who the practice Safeguarding lead was and told us that they would contact this person should they have any safeguarding concerns. We were told that locum doctors who work at the practice are provided with a copy of the safeguarding procedure.

Senior staff confirmed that all staff had completed the mandatory safeguarding training. We selected a random sample of patient records to review, all of whom had certificates on their files to confirm that they had undertaken the required training.

Effective care

Safe and clinically effective care

Senior staff told us that the practice uses the Datix reporting system and yellow card report as and when required for incidents which are identified.

Significant events can be identified and reported by all staff. When incidents are identified and reported, they are discussed at the clinical meeting by relevant staff. Staff informed us that it is at this meeting that recommendations for improvement are discussed and agreed. Once improvements have been implemented, the issue is monitored and subsequently followed up approximately six months later to check on the status of the initial issue to ensure no further issues have re-occurred.

As previously mentioned, as part of our review of clinical records, we identified an issue relating to a patient that should have been seen in secondary care as an 'urgent' referral, following the referral made by the practice. Once the practice identified that the patient had not been seen, the matter was appropriately chased up. However, the practice did not complete a Serious Event to the health board to highlight the fact that the patient had not been seen in secondary care within the required timescales.

An additional issue was also identified. Following a blood test, the decision was made by the Advanced Nurse Practitioner to ask the relevant patient to return for further tests in two weeks. However, upon seeing the results, the doctor requested that the patient started treatment for diabetes immediately. This issue evidences the importance of a robust audit system to ensure clinical decisions are routinely scrutinised.

Clinical meetings are arranged as and when required, to discuss any new NICE guidelines / best practice, which have been introduced, to determine how the changes can be incorporated into the practice.

Any safety alerts or best practice examples that are received, are circulated to relevant staff within the practice. The practice manager requests a read receipt to ensure that they have been read by the relevant staff at the practice.

Improvement needed

The practice is required to provide HIW with details of the action taken to ensure an effective audit system of patient medical records is in place, to ensure clinical decisions are scrutinised.

Record keeping

Overall, record keeping within the patient medical records we reviewed was of a satisfactory standard. However, we did identify issues that require improvement relating to the quality of information being recorded by staff within patient records. There needs to be a system implemented to ensure that clinical notes are regular reviewed to ensure an acceptable standard is being maintained.

As previously mentioned, as part of our review of patient clinical records we identified inconsistencies in the recording of evidence to indicate when patient consultations had taken place. Also, in some instances there was no evidence to demonstrate when information has been provided to patients relating to their condition, any investigations and their care management options.

We also identified issues in regards to the timeliness of the notes being recorded by clinical staff following clinical encounters with patients. In one case reviewed, the notes were documented six days after the patient had been seen by the doctor.

Read codes were not being used consistently by clinicians at the practice. There was also no evidence to demonstrate that any audits of read coding had been carried out within the practice to ensure consistency.

Senior staff told us that audits of patient records do take place on a quarterly basis. However, given the findings outlined above the practice should review the audit process to ensure consistency in relation to the recording of evidence within patient clinical records.

Improvement needed

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

- ensure patients' medical records clearly reflect where consultations have taken place
- ensure relevant staff are consistently using Read coding
- ensure there is an appropriate system in place to regular review the quality of clinical records being maintained by staff working at the practice
- ensure notes are recorded into the electronic record contemporaneously or within one working day following clinical encounters with patients.

Quality of management and leadership

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

At the time of our inspection, the practice was owned and operated by one GP partner. A practice manager was in post and good working relationships between the management and the practice team were demonstrated. Since our last inspection the practice had also appointed an assistant practice manager to assist with the management of the practice.

The practice is well run by the practice manager who takes a lead role in the managing of all non-clinical activities. Staff we spoke with were happy working at the practice and felt fully supported in carrying out their relevant roles.

The practice had taken a number of steps in attempting to reduce the burden on the GP, whilst also ensuring patients were being seen by an appropriate healthcare professional.

What improvements we identified at the last report

Areas for improvement identified at the last inspection included the following:

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

  a) provide effective leadership and to promote the development of the clinical team within the practice;

  b) demonstrate how business decisions are being made.

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

What actions the service said they would take

The service committed to take the following actions in their improvement plan:

- Clinical meetings have been set up with the GP taking the lead for all clinical aspects.
- The practice will introduce more formal meetings between GP and Practice Manager to demonstrate how business decisions are made and agreed.
- This (DBS checking process) has been in place within the practice for many years. However, a policy will be introduced to carry out security checks in the interim pending DBS checks. Unfortunately existing staff had DBS checks done previously not using the electronic system for checking. However all new staff will have a DBS check.

What we found on follow-up

We were told that regular clinical meetings are held for all clinical staff to discuss any issues as well as the development of the services being provided from the practice.

Senior staff told us that the GP and Practice Manager have discussions on a daily basis in regards to emerging or ongoing issues. There was also a formal meeting held once a month for which minutes and any decisions are recorded.

There was a written DBS policy in place. The practice maintained a list of all staff DBS reference numbers and date of which the DBS certificate was provided.

Governance, leadership and accountability

At the time of our follow up inspection, the practice was owned and operated by one GP partner. A Practice Manager was in post and responsible for the day to day management of the practice. There was also an Assistant Practice Manager in post to assist with the management of the practice. The practice had made attempts to appoint a second partner or salaried GP to support the existing management team. However, the practice had been unsuccessful. In the interim, we were informed that there were two GPs that work regularly at the practice to ensure a suitable level of service to patients was maintained.

The practice is well run by the Practice Manager who takes a lead role in the managing of all non-clinical activities. Staff we spoke with were happy working at the practice and felt fully supported in carrying out their relevant roles.

It was clearly evident from our visit that the practice team were determined and committed to provide a quality services to patients. A patient focussed approach was clearly demonstrated.

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

Senior staff told that meetings with the health board are held on an annual basis to discuss the practice annual contract review. We were also informed that workforce planning meetings had previously taken place with the health board. However, senior staff felt that overall there had been a lack of support from the health board's Primary Care Team in relation to the pressures that the practice had been under.

We were told that regular staff meetings take place at the practice. Minutes are recorded and circulated to all staff for review. There are also monthly MDT meetings which are attended by palliative care staff, a district nurse and safeguarding.

Regular formal clinical meetings had been implemented following on from the previous HIW visit. These meetings allowed clinical staff within the practice to discuss any issues or concerns they had, as well as to discuss issues relating to the future development of the services being provided at the practice.

We were told by senior staff that monthly formal meetings between the Practice Manager and the lead GP have now been established which are minuted to discuss emerging and ongoing issues relating to the practice.

A range of up to date written policies and procedures was readily available to guide staff in their day to day roles to promote safe and effective care. Staff we spoke to were aware of how to access the practice policy documents. New staff have to confirm with the Practice Manager that they have read and understood the policies and procedures in place. Any policies which are amended are circulated to all staff, who subsequently have to confirm to the Practice Manager that they have reviewed the updated document.

The practice was part of a local GP cluster. We were told that the lead GP and Practice Manager attend the cluster meetings regularly. Senior staff informed us that any issues or learning received from the cluster meetings was fed back during relevant staff meetings.

The practice also engages in collaborative working with the 'buddy system' with another practice. We were told that the practice managers from each practice regularly meet to discuss options in relation to sustainability and the concerns around being a single GP practice. The practice feels there has been a lack of support from the health board with regards to this matter.

Staff and resources

Workforce

Staff we spoke to were able to describe their roles and responsibilities, which contributed to the overall operation of the practice. Staff we spoke to told us they were happy in their roles and felt supported by colleagues within the practice.

We were told by staff that their training requirements were discussed during their appraisal meetings, but should they have a preference to attend additional training they would feel they would be fully supported by the Practice Manager. Staff we spoke to showed a willingness to develop their roles for their own professional development and to facilitate the effective running of the practice.

There was a training matrix available but as previously detailed, we were also told by senior staff that the practice was now using Croner, which was an internet training package which logged and monitored training required and undertaken by staff. This meant that reminders were sent to the relevant staff member and the Practice Manager when training was due.

We reviewed a sample of staff files which included staff contracts of employment and job descriptions. There was also evidence to demonstrate that appropriate DBS checks had been completed for staff.

The practice had been unable to recruit an additional GP to work at the practice, despite the efforts made. Steps have been taken by the practice in attempt to reduce the demand for appointments with the GP, whilst also ensuring patients are being seen by an appropriate healthcare professional. For example, the practice has recruited an additional Advance Nurse Practitioner, to deal with all emergency patients at the practice.

Since the previous HIW inspection, an Assistant Practice Manager had been appointed to assist with the management of the practice.

We were told by senior staff that arrangements were in place for staff at the practice to access Occupational Health support via another GP surgery. We were also told that staff had been provided with information detailing how they can access this support. However, during our discussion with staff, the majority were unaware of this arrangement.

Improvement needed

The practice is required to provide HIW with details of the action taken to increase staff awareness of the arrangements in place to access Occupational Health support.

4. What next?

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

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

The improvement plans should:

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

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

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

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

5. How we conduct follow-up inspections

Follow-up inspections can be announced or unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection. In some circumstances, we will decide to undertake an announced inspection, meaning that the service will be given up to 12 weeks' notice of the inspection.

The purpose of our follow-up inspections is to see what improvements the service has made since our last inspection.

Our follow-up inspections will focus on the specific areas for improvement we identified at the last inspection. This means we will only focus on the Health and Care Standards 2015 relevant to these areas.

During our follow-up inspections we will consider relevant aspects of:

- Quality of patient experience
- Delivery of safe and effective care
- Management and leadership

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels. We will also highlight any outstanding areas of improvement that need to be made.

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

Appendix A – Summary of concerns resolved during the inspection

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

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

Appendix B – Immediate improvement plan

Service: Llanyravon GP Surgery

Date of inspection: 24 June 2019

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

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
No immediate concerns were identified during this inspection.				

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

Service representative:

Name (print):

Job role:

Date:

Appendix C – Improvement plan

Service: Llanyravon GP Surgery

Date of inspection: 24 June 2019

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

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The practice should consider organising the information contained within the waiting room area into themes, to assist patients in identifying the information most appropriate to them.	1.1 Health promotion, protection and improvement	Agreed and undertaking revamp of notice boards in waiting area	Sophie Jones	3 Months
The practice is required to provide HIW with details of the action taken to ensure all patient consultation / treatment rooms have curtains available around the couches within the room.	4.1 Dignified Care	The clinical room without curtain is not used to carry out examination therefore we do not feel it needs a curtain as explained in previous visit when questioned about it.	N/A	N/A

Improvement needed	Standard	Service action	Responsible officer	Timescale
The practice is required to provide HIW with details of the action taken to: • update the consent policy. • ensure a record is made within patients' medical records when information / advice is provided to patients.	4.2 Patient Information	Consent policy was updated during the HIW visit. This will be a standard agenda item for all clinical meetings to remind staff to record information leaflets within patient records	N/A All clinical staff	N/A Ongoing
The practice is required to provide HIW with details of the action taken to implement a workflow policy.	3.2 Communicating effectively	We now have this in draft form which will be formalised by the end of September	Jane Bedding	2 months
The practice is required to provide HIW with details of the action taken to: • implement and maintain a formal system of in house second opinions. • implement and maintain a formal system of peer review of outcomes of	5.1 Timely access	We have contacted neighbouring practices about this but unfortunately they do not have the time to commit. The only outcome for this is for us to undertake this once a month when we employ a locum. We also get second opinions from secondary care specialities and advice lines.	Dr Alun Hughes Dr Alun Hughes	Ongoing Quarterly

Improvement needed	Standard	Service action	Responsible officer	Timescale
patient referrals and GP patient referral patterns/rates.		Dr will ensure that he does peer reviews on the advanced nurse practitioner		
The practice is required to provide HIW with details of the action taken to ensure annual patient surveys are undertaken.	6.3 Listening and Learning from feedback	We will re-instate the patient surveys October/November 2019	Jane Bedding	4 months
Delivery of safe and effective care				
The practice is required to provide HIW with details of the action taken to: • ensure that all light fittings at the practice is safely secured. • ensure risk assessments which are completed are reviewed annually. • ensure a risk register is implemented which details all practice risks and mitigating actions taken.	2.1 Managing risk and promoting health and safety	This has previously been confirmed verbally via telephone conversation between HIW inspector and practice manager, no further action needed. These are completed annually, except for fire risk assessment which is every 3 years unless major alterations take place. Started at visit to take notes on this, will be in place end of September.	Jane Bedding Jane Bedding, Sophie Jones Jane Bedding, Sophie Jones	Completed Annually 3 months

Improvement needed	Standard	Service action	Responsible officer	Timescale
• ensure that serious incidents and events are reported to the health board as appropriate in accordance with local requirements		All significant events are reported and dealt with in house and submitted to the local health board annually, however, staff are aware that serious incidents must be reported via datix or yellow card and all staff will be reminded of their responsibilities to do this.	All clinical staff	Ongoing
The practice is required to provide HIW with details of the action taken to: • regularly review the prescribing system. • ensure an adequate, auditable system is in place for logging and tracking changes made to patient medication by staff. All clinical staff must be trained in the use of this system.	2.6 Medicines Management	Aneurin bevan university health board prescribers visit the practice regularly and run audits on medication and prescribing and keep the notes up to date. We carry out regular audits on repeat prescribing and remove medication that have not been issued in 12months. We also make sure that medication removed from repeat list is annotated as to why and reports are given to clinical staff if this has not been carried out correctly. Protocols in places for removing/reviewing medication.	LHB All clinical staff	Ongoing 3 months

Improvement needed	Standard	Service action	Responsible officer	Timescale
• Ensure lessons learned from serious events are shared internally and externally.		As stated above serious events are reported to datix, however, this will be a standard item on clinical meeting agenda. Significant events are dealt with immediately when raised and discussed at clinical meetings.	All staff	As and when needed
The practice is required to provide HIW with details of the action taken to ensure an effective audit system of patient medical records is in place to ensure clinical decisions are scrutinised.	3.1 Safe and Clinically Effective care	We will implement an audit once a month carried out on a random selection of patients medical records who have been seen in the last month to ensure notes are up to standard any outstanding tasks have been followed up. EMIS alerts practice manager of any outstanding tasks to be completed related to patients future care.	Jane Bedding	Monthly
The practice is required to provide HIW with details of the action taken to: • ensure patients' medical records clearly reflect where consultations have taken place.	3.5 Record keeping	We have taken on board that entries into patients notes must state from the start of the consultation where it has taken place and not as a sub read code (which has happened on a few occasions). Dr made aware of how to read code this properly for the future.	Dr Alun Hughes	Ongoing

Improvement needed	Standard	Service action	Responsible officer	Timescale
• ensure relevant staff are consistently using Read coding.		We have a standardised read code list that is attached to every clinical member of staff's notice board for them to all use the same read codes on patient's notes. Note sure what this means	Jane Bedding	Monthly
• ensure there is an appropriate system in place to regular review the quality of clinical records being maintained by staff working at the practice.		As stated above, monthly audits will be carried out with patient's medical records.	Jane Bedding, Sophie Jones	Monthly
• ensure notes are recorded into the electronic record contemporaneously or within one working day following clinical encounters with patients.		All clinical staff aware that medical records should be updated immediately at the time of consultation or directly after house calls. We have in iPads which we will try to implement the use of again in the practice. Practice manager will send out reminders to all staff including locums to ensure they add their consultations in a timely manner.	Jane Bedding	Immediately
Quality of management and leadership				
The practice is required to provide HIW with details of the action taken to increase staff	7.1 Workforce	Misunderstanding from staff. We do not have open access to occupational health	Jane Bedding	Required as and when

Improvement needed	Standard	Service action	Responsible officer	Timescale
awareness of the arrangements in place to access Occupational Health support.		support this is only done if a staff member has been off sick or has a disability and this is carried out by the practice manager with neighbouring GP practice. Staff do have 24hour support through Croner which they can access for wellbeing and other personal issues.		support needed

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

Service representative

Name (print): Jane Bedding

Job role: Practice Manager

Date: 1st August 2019