Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection (Announced)

Hillcrest Medical Centre / Betsi Cadwaladr University Health Board

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

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: **0300 062 8163**

Email: **hiw@gov.wales**

Website: **www.hiw.org.uk**

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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 inspection of Hillcrest Medical Centre at 86 Holt Road, Wrexham, LL13 8RG, within Betsi Cadwaladr University Health Board on the 3 December 2019.

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

HIW explored how the service met the Health and Care Standards (2015).

Further details about how we conduct GP inspections can be found in Section 5 and on our website.

2. Summary of our inspection

Overall, we found evidence that Hillcrest Medical Centre provided safe and effective care. However, we found some evidence that the practice was not fully compliant with all Health and Care Standards in all areas.

This is what we found the service did well:

- Patient information and engagement
- Patients were treated with dignity and respect by all staff
- Records of patient consultations were of a good standard
- Dedicated care navigation team
- Internal and external communication
- Welcoming environment.

This is what we recommend the service could improve:

- Appoint a Carers' Champion
- Undertake regular medication case reviews and prescribing audits
- Reinstate safeguarding multidisciplinary team meetings
- Implement a standardised set of READ coding across the practice
- Clear backlog of summarising notes and READ coding.

3. What we found

Background of the service

Hillcrest Medical Centre has been managed by Community Care Collaborative (CCC) since 1 November 2019. CCC is an innovative model of general practice that meets the medical, social and pastoral needs of its patients. Hillcrest Medical Centre currently provides services to approximately 5650 patients in the Wrexham area. The practice forms part of General Practice (GP) services provided within the area served by Betsi Cadwaladr University Health Board.

The practice employs a staff team which includes three salaried GPs, one locum GP, five advanced clinical practitioners (ACP), four registered nurses, three healthcare assistants, two specialist care navigators, four care navigators / administrative staff and three business leads. The team is supported by the Chief Executive and Service Director of CCC.

The practice provides a range of GP services; including

- Dermatology
- Minor surgery
- Clinics
- Women's health
- Management of chronic conditions such as high blood pressure, asthma, diabetes, COPD
- Immunisations for adults and children
- Smear tests and contraception
- Mental Health services including anxiety, low mood, eating disorders and addictions
- Minor illnesses such as bites, ear and skin infections
- Allergies

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.

We found that the practice were aiming to provide a high quality experience to their patient population.

We found relevant and up to date information displayed in the reception and waiting area, in both English and Welsh.

Before our inspection we invited the practice to hand out HIW questionnaires to patients to obtain their views on the service provided. We only received three completed questionnaires.

On the day of the inspection, our inspectors also spoke with several patients to find out about their experiences at the practice.

Staying healthy

We found that patients were being encouraged to take responsibility for managing their own health, through the provision of health promotion advice from staff, and written information within the waiting area and consulting rooms. There was also a television monitor within the waiting area displaying health promotion information and information about the practice.

We found that the practice used care navigators[1] to signpost patients to appropriate professionals better placed to assist them, to ease the pressure on the clinical staff within the practice.

[1] Care navigators are trained to ensure patients are seen by the right person

People with caring responsibilities were identified and given advice and information about services that may be able to provide them with support. We found that the practice did not have a Carers' Champion that would act as a voice for carers within the practice and be a key point of contact for carer information. We were verbally assured by the practice that plans are already in place for this role to be undertaken by the care co-ordination team.

A sign displaying 'No Smoking' was displayed which confirmed the emphasis being placed on compliance with smoke free premises legislation[2].

Improvement needed

Ensure that a Carer Champion is appointed and details advertised to patients.

Dignified care

We saw staff greeting people in a professional yet very friendly manner at the reception desk and during telephone conversations.

We considered the physical environment and found that patient confidentiality and privacy had been considered. The practice had arrangements to protect patients' privacy, including areas for patients to have private conversations with staff. Telephone calls were also received, in privacy, away from patients.

We were informed by the practice that imminent plans were in place to improve the waiting area and reception room. The reception area is to be opened up to create a more friendly and approachable area. The waiting room will be refurbished to create dedicated confidential areas for patients' prescription issues and reviews.

Doors to individual consultation and treatment rooms were kept closed when staff were attending to patients. Curtains were also provided around examination

[2] The Smoke-free Premises etc. (Wales) (Amendment) 2015 - Legislation to ban smoking in enclosed public places was introduced in 2007 to protect the public from second-hand smoke.

couches. This meant that staff were taking appropriate steps to maintain patients' privacy and dignity during consultations.

The right to request a chaperone was clearly advertised around the practice. We were informed that the use of chaperones is also verbally offered to patients in the consulting and treatment rooms. We were informed that there are two non-clinical members of staff at the practice who act as chaperones and have been provided with relevant guidance and training.

Patient information

As previously mentioned, leaflets on health related issues were available for patients, within the waiting area and consulting rooms. This included information on local support groups, health promotion advice and self-care management of health related conditions.

We found that the practice made efforts to ensure that patients were seen in a timely manner. Staff described a process for keeping patients informed about any delays to their appointment times.

Information relating to practice opening times and out of hours was advertised on the practice website and patient leaflet.

Communicating effectively

We were informed that several members of staff can communicate bilingually with patients. We found that this service was being promoted by staff identifying themselves by wearing the Iaith Gwaith lanyard. The Iaith Gwaith brand is an easy way of promoting Welsh services by identifying Welsh speakers.

A hearing loop was provided in order to aid communication with those patients with hearing difficulties.

Timely care

Patients were able to pre-book routine appointments in advance, Monday to Friday, over the phone. We also saw that the practice held same day, urgent

appointments for patients. The practice also made use of the My Health Online[3] facility to request repeat prescriptions. The use of this facility is to be encouraged as it could ease pressure on the telephone lines.

We found that referrals to other specialists were made in a timely fashion by the practice. However, the practice did not have a formal system in place to ensure referrals had been received and acted upon. We also found that the practice did not have a formal system in place for ensuring all incoming clinical information is reviewed by a GP.

Our concerns regarding the referral letters and incoming clinical information were dealt with under our immediate assurance process. This meant that we wrote to the practice immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in Appendix B.

Individual care

Planning care to promote independence

The practice team knew patients very well and made adjustments according to people's individual needs based on this knowledge.

All the GP consulting rooms, clinical rooms and treatment rooms were located on the ground floor. The consulting rooms, clinical rooms and treatment rooms were spacious and very well equipped.

There was adequate disabled access to the building with a number of parking spaces provided within the adjoining car park with dedicated disable parking bays.

People's rights

The practice had made arrangements to make services accessible to patients with different needs and language requirements, as described above.

[3] https://www.myhealthonline-inps.wales.nhs.uk/mhol/home.jsp

We noted that the practice had a dedicated equal opportunities policy in place. This meant that the practice was committed to ensuring that everyone had access to the same opportunities and to the same fair treatment.

Staff we spoke with were aware of their responsibilities in relation to equality and diversity.

Listening and learning from feedback

We found that the practice did not have a patient participation group (PPG) in operation whilst it was managed by the Health Board. However, we saw evidence that CCC had made arrangements for this group to be reinstated. PPGs provide invaluable information for practices regarding the services provided and encompasses direct patient experiences.

There was a formal complaints procedure in place, and information about how to make a complaint was available on the practice's website. However, we found no information on display in the waiting area. NHS (Wales) Putting Things Right[4] information was available.

We were told that emphasis was placed on dealing with complaints at source, in order for matters to be resolved as quickly as possible and to avoid any need for escalation.

We discussed the practice's mechanism for seeking patient feedback. The practice informed us that plans are in place for patient surveys to be reintroduced from January 2020. We also advised the practice to display an analysis of the feedback received in the waiting area / reception, demonstrating to patients that feedback is acted upon and is used to influence changes to the service delivery which the practice agreed to do.

[4] Putting Things Right is a process for dealing with Complaints, Claims and Incidents which are collectively termed "Concerns". This represents a significant culture change for the NHS in Wales in the way in which it deals with things that go wrong, introducing a single and consistent method for grading and investigating concerns, as well as more openness and involvement of the person raising the concern.

Improvement needed

Ensure that information relating to the practice's internal complaints process is made available within the waiting area.

Delivery of safe and effective care

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

We found a staff team who were very patient centred and committed to delivering a high quality service to their patients.

Information was available to patients bilingually to help them take responsibility for their own health and well-being.

The sample of patient records we reviewed were of good standard.

There was a safeguarding of children and vulnerable adults' policy in place and staff had completed training in this subject.

Safe care

Managing risk and promoting health and safety

During a tour of the practice building, we found all areas where patients had access, to be clean and uncluttered, which reduced the risk of trips and falls.

As previously mentioned in the report, the practice has a range of plans in place to improve the environment. We saw detailed plans for the imminent refurbishment of the reception and waiting area.

General and more specific health and safety risk assessments were undertaken on a regular basis. Fire safety equipment was available at various locations around the practice and we saw these had been serviced regularly.

Emergency exits were visible and a Health and Safety poster was displayed within the practice.

Infection prevention and control

There were no concerns expressed by patients over the cleanliness of the practice.

There was a clear and detailed infection control policy in place and we saw evidence that an audit had recently been completed.

We saw that staff had access to personal protective equipment such as gloves and disposable plastic aprons to reduce cross infection. The clinical treatment areas we saw were visibly clean.

We saw that the curtains in the treatment rooms were disposable, meaning that they could be easily replaced should they become contaminated or dirty. This demonstrates a good commitment to infection prevention and control.

Hand washing and drying facilities were provided in clinical areas and toilet facilities. Hand sanitizers were also readily available around the practice.

During our inspection, the practice was not able to provide any evidence of Hepatitis B immunisations for clinical staff working at the practice.

Our concerns regarding Hepatitis B immunisations for clinical staff were dealt with under our immediate assurance process. This meant that we wrote to the practice immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in Appendix B.

Waste had been segregated into different coloured bags/containers to ensure it was stored and disposed of correctly. Clinical waste was securely stored until it could be safely collected.

We noted that the practice had a large amount of toys in the waiting room for children. For the purpose of infection prevention and control, we recommend that the practice reviews the selection of toys available as part of their infection prevention and control audit.

Improvement needed

The practice should review the selection of toys made available to children as part of their infection prevention and control audit.

Medicines management

Repeat prescriptions could be requested in person or by post at the practice by completing the computer tear-off list or by using the My Health Online facility. It was noted that the practice endeavoured to return prescriptions to patients within 48 hours. No telephone repeat prescriptions were accepted by the practice for safety reasons.

However, we were not fully assured that regular case reviews or prescribing audits had been undertaken to ensure any medications no longer needed, or being taken, were removed from the repeat prescription list. We were informed by the CCC that plans have already been put in place to improve medicine management at the practice. A dedicated medicine management hub team is being put in place with a dedicated pharmacy technician who will be supporting the care navigator team and all aspects of prescribing at the practice. The practice must ensure that regular case reviews and prescribing audits are undertaken to ensure that patients are prescribed the correct medication.

Improvement needed

The practice must ensure that regular case reviews and prescribing audits are undertaken.

Safeguarding children and adults at risk

We found that there were child protection and adult safeguarding policies and procedures in place. The practice had identified a member of staff as the nominated safeguarding lead.

We were informed by the practice that locum GPs have access to the 'All Wales Child Protecting Procedures' which are held in reception. We recommend that the procedures are also included within the practice induction pack for sessional GPs.

We were told that all existing and new staff had received safeguarding training at level one and level two, with all clinical staff trained at level three. We were also informed that safeguarding issues is a standard item on the practice weekly meetings. We found that staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies.

We found that adult and child safeguarding cases were flagged via their electronic system. However, we noted that the practice have had issues where patient records have still been flagged for children who are no longer on the register. We were informed that the Multidisciplinary Team Meetings (MDT) for safeguarding had lapsed at the practice over the last three years. We were verbally assured that plans are in place for MDT meetings to be reinstated as soon as possible.

The practice described the pre-employment checks that would be undertaken for any new members of staff before they joined the practice. This included checking of references and / or undertaking Disclosure and Barring Service[5] (DBS) checks on staff appropriate to the work they undertake. However, during our inspection the practice was not able to demonstrate that all relevant staff had received a DBS check. This also included non-clinical staff who are appointed chaperones.

Our concerns regarding the DBS check were dealt with under our immediate assurance process. This meant that we wrote to the practice immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in Appendix B.

Improvement needed

Ensure that the 'All Wales Child Protecting Procedures' are included within the practice induction pack for sessional GPs.

Reinstate MDT safeguarding meetings to ensure correct cases are flagged on the electronic system.

Medical devices, equipment and diagnostic systems

We found that portable electrical appliances were being tested on a regular basis.

Emergency drugs and equipment kept at the practice were seen to be stored appropriately for ease of access in an emergency situation. The practice had a system to evidence that checks were being carried on a regular basis. However,

[5] The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. It replaces the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA).

we did recommend to the practice that the emergency drugs kit should also contain cyclizine[6] and glucagon[7].

Improvement needed

Ensure that the emergency drugs kit contains cyclizine and glucagon.

Effective care

Safe and clinically effective care

The practice had suitable arrangements in place to report patient safety incidents and significant events. The practice made use of the Datix[8] system for reporting incidents. Significant events were being recorded and discussed at weekly clinical meetings.

Information governance and communications technology

We found that there were information governance policies and procedures in place. Staff members we spoke with were aware of how to access this information.

Record keeping

A sample of patient records were reviewed. Overall, we saw evidence that staff were keeping good quality clinical records. In all cases, the records contained sufficient detail of consultations between clinical staff and patients, and it was possible to determine the outcome of consultations and the plan of care.

[6] Cyclizine is a medication used to treat and prevent nausea, vomiting and dizziness.

[7] Glucagon injection is an emergency medicine used to treat severe hypoglycemia (low blood sugar) in diabetes patients treated with insulin who have passed out or cannot take some form of sugar by mouth.

[8] Datix is a patient safety web-based incident reporting and risk management software for healthcare and social care organisations.

However, we found inconsistent use of READ coding[9] being used across the practice. We also noted that medication was not always being linked to medical conditions within the sample of patients' notes we examined.

We were informed by CCC that they had inherited significant issues with regards to READ coding when they took over the practice in November 2019. At the time of our inspection, we were informed that the practice is about one year behind on summarising notes and READ coding. We were informed that the backlog had occurred due to staffing issues over the past few years. CCC verbally assured us that they are in the process of developing a standard READ coding set to be implemented urgently at the practice. We were also informed that CCC are considering options and resources available for the backlog of summarising notes and READ coding.

Improvement needed

Ensure that a standardised set of READ coding is implemented across the practice.

Ensure a reasonable plan is put in place to clear the backlog of summarising notes and READ coding.

Ensure that medication is always linked to medical conditions within patients' notes.

[9] Read codes are the standard clinical terminology system used in General Practice in the United Kingdom. It supports detailed clinical encoding of multiple patient phenomena including: occupation; social circumstances; ethnicity and religion; clinical signs, symptoms and observations; laboratory tests and results; diagnoses; diagnostic, therapeutic or surgical procedures performed; and a variety of administrative items.

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.

We found a very patient-centred staff team who were competent in carrying out their duties and responsibilities to provide the best service they could and were supported by a dedicated leadership team. We observed staff supporting each other and worked very well together as a team.

Overall, the practice was well managed by a committed and dedicated management team who operated an open and approachable managerial ethos, which enabled staff to be confident to raise issues.

Governance, leadership and accountability

Hillcrest Medical Centre is managed by both the Chief Executive and Service Director of CCC. The practice is supported by three Business Leads and we found the practice to have strong leadership.

It was observed that there were respectful and courteous relationships between all staff within the practice. We were informed by staff that they felt able to raise any issues with the leadership team and that issues would be addressed in a comprehensive and thorough manner. Staff told us that they have seen significant improvement made at the practice since it has been taken over by CCC. The leadership team demonstrated inclusive approaches to management, promoting openness and transparency with all staff and its patients.

We found a patient-centred staff team who were very committed to providing the best services they could. Staff were very positive about the working environment and they all felt well respected and supported by their colleagues.

We also found an atmosphere of positivity at the practice. During our conversations with patients and staff we detected some excitement and

enthusiasm about the changes and improvements made to date at the practice and those planned for the imminent future.

There was a whistleblowing policy in place and all staff told us they felt able to raise concerns.

The practice is part of a local cluster group[10] and both the Service Director and one of the three Business Leads regularly attended these meetings. The engagement with the cluster group was reported as being very good and working well together.

Staff had access to policies and procedures to guide them in their day to day work. We were informed that CCC are currently in the process of reviewing and updating all relevant policies and procedures since they took over in November 2019.

Staff and resources

Workforce

The practice had an established reception and administration team in place. Discussions with staff, and a review of a sample of staff records, indicated that staff, generally, had the right skills and knowledge to fulfil their identified roles within the practice. Staff had received an annual appraisal or plans were in place.

All staff we spoke with confirmed they had opportunities to attend relevant training. We were provided with information relating to mandatory training following our inspection which showed that the majority of staff had completed mandatory training and plans were in place for staff to renew their training where applicable.

We saw that there were formal recruitment policies and procedures in place.

[10] A Cluster is a grouping of GPs working with other health and care professionals to plan and provide services locally. Clusters are determined by individual NHS Wales Local Health Boards (LHB's).

4. What next?

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

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

The improvement plans should:

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

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

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

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

5. How we inspect GP practices

GP inspections are usually announced. GP practices will receive up to 12 weeks notice of an inspection. This is so that arrangements can be made to ensure that the practice is running as normal, and that the inspection causes as little disruption to patients as possible.

Feedback is made available to practice representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

We check how GP practices are meeting the Health and Care Standards 2015. We consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within GP practices.

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

Appendix A – Summary of concerns resolved during the inspection

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

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

Appendix B – Immediate improvement plan

Service: Hillcrest Medical Centre

Date of inspection: 3 December 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
Finding: The practice did not have a system in place to ensure referrals have been received and acted upon. **Improvement needed:** The practice must put in place a formal system for the monitoring of all referrals, with standard timescales, to ensure patients are being seen in a timely way.	Standard 3.1 Safe and Clinically Effective Care and Standard 5.1 Timely access	The current system is managed by the practice secretary. The process includes the secretary historically reviewing all referrals on a daily basis. This is proving to be time consuming, therefore going forward we have invited feedback from the Wrexham Cluster leads. Feedback given was as below. Standardised referral process, where every referrer uses lexacom and referrals are electronically sent	Dewi Richards	10.12.19

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		to the clinical admin team for continued follow up. We will also do a weekly search on WCCG for any parked referrals. Furthermore we will conduct a 2 weekly search for USC referrals and monthly for urgent referrals. These will then be reviewed by the authorising clinician. We will hand out a slip to patients requesting them to call surgery if they have not received an appointment within a designated time scale.		
Finding: The practice did not have a system in place for ensuring all incoming clinical information is reviewed by a GP. **Improvement needed:**	Standard 3.1 Safe and Clinically Effective Care	The process as of the 1.11.19 is as follows:- Received and Date stamped by clinical admin	Dr Sankey / Cat Dobbins	Interviews to commence week 16.12.19

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
The practice must put in place a formal system to ensure all incoming clinical information is reviewed by a GP.	and Standard 5.1 Timely access	Seen and actioned by senior clinicians (consultant G.P and ACP) on the same day and signed. Once actioned referral is returned for scanning and coding by clinical admin secretary. To further improve further we will Plan – we have identified a shortage in clinical admin staffing. We are recruiting new staff to support the practice to complete these tasks in a timely manner. Advert is out on CCC website. The practice will utilise practice unbound for work optimisation. This is an electronic system funded via the Wrexham cluster.		

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		Dr Sankey and Business lead will implement in house training for all relevant staff.		
Finding: The practice was not able to provide evidence of Hepatitis B immunisations for clinical staff. **Improvement needed:** The practice must provide evidence that all clinical staff have been immunised against Hepatitis B.	Standard 2.4 Infection Prevention and Control (IPC) and Decontamination	All clinical staff who have previously received Hep B injections to provide proof of immunisation. Contacted BCUHB Occy health department on 16.12.19 to book all outstanding staff in for Heb B vaccinations. Awaiting response and guidance over developing a risk assessment. At present all staff who are not currently vaccinated have been requested to refrain from dealing with bodily fluids until the matter is resolved. Certificate to be stored in staff HR File.	Dewi Richards	18.12.19

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
Finding: The practice was not able to demonstrate that relevant staff had received a renewal Disclosure and Barring Service (DBS) check. This included non-clinical staff who are appointed chaperones. **Improvement needed:** The practice must provide evidence that all staff have received a DBS check relevant to their roles.	**Standard 7.1 Workforce**	All staff currently working in CCC have an up to date DBS – due to the TUPE transfer we are in the process of renewing all TUPE staff DBS over to CCC DBS. This can take several weeks therefore we have completed a DBS risk assessment for all staff awaiting new DBS.	Dewi Richards	Submission of all TUPE staff DBS by 18.12.19

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: Community Care Collaborative

Name (print): Dewi Richards

Job role: Service Director

Date: 18.12.19

Appendix C – Improvement plan

Service: Hillcrest Medical Centre

Date of inspection: 3 December 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				
Ensure that a Carers' Champion is appointed and details advertised to patients.	1.1 Health promotion, protection and improvement	Joanne Young has been appointed to lead on carers support services. Coffee morning held on 20.12.19 with carers invited in. Poster in reception and awaiting upload of information to website.	JY	completed
Ensure that information relating to the practice's internal complaints process is made available within the waiting area	6.3 Listening and Learning from feedback	Putting things Right documentation is now on website and in waiting area	FD	completed
Delivery of safe and effective care				

Improvement needed	Standard	Service action	Responsible officer	Timescale
The practice should review the selection of toys made available to children as part of their infection prevention and control audit.	2.4 Infection Prevention and Control (IPC) and Decontamination	All non-wipeable toys removed following inspection in accordance with IP guidelines.	PP	completed
The practice must ensure that regular case reviews and prescribing audits are undertaken.	2.6 Medicines Management	MDT takes place every Tuesday and Friday 1-2pm led By Dr Sankey. Pharmacy secured from BCUHB for period of 2 years who will oversee audit and medication reviews.	GY pharmacy lead	In place
Ensure that the 'All Wales Child Protecting Procedures' are included within the practice induction pack for sessional GPs.	2.7 Safeguarding children and adults at risk	Added to packs following review	FD	In place
Reinstate MDT safeguarding meetings to ensure correct cases are flagged on the electronic system.		Weekly safeguarding session held by social worker and ANP, documented on EMIS.	NA	In place
Ensure that the emergency drugs kit contains cyclizine and glucagon.	2.9 Medical devices, equipment and diagnostic systems	Actioned following review, order submitted awaiting delivery of medication	CD	14.2.2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
Ensure that a standardised set of READ coding is implemented across the practice.	3.5 Record keeping	Following a review of enhanced services this identified a list of which codes are needed. This list will be distributed to all clinicians and non-clinicians once finalised	CD	29.2.2020
Ensure a reasonable plan is put in place to clear the backlog of summarising notes and READ coding.		Discussions with BCUHB ongoing, audit conducted by senior governance officer and clinician to better understand the backlog. Rescue plan being implemented by the Community care Collaborative which includes staff overtime to tackle the backlog of summarising and hopefully will gain support by BCUHB following audit.	DR	August 2020
Ensure that medication is always linked to medical conditions within patients' notes.		Medicines management team to provide training for team at next PDP 7.4.2020	GY	April 2020
Quality of management and leadership				
N/A				

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): Dewi Richards

Job role: Service Director

Date: 11.2.2020