Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Nantymoel Surgery, Cwm Taf Morgannwg University Health Board

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

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

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

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

Our goal

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

Our priorities

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

Contents

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Nantymoel Surgery, Cwm Taf Morgannwg University Health Board on 3 August 2023.

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

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. A total of 23 were completed. We also spoke to staff working at the service during our inspection. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

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

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
We found staff at Nantymoel Surgery to be committed to providing a caring, professional and positive experience to patients. Throughout the inspection we witnessed staff speaking to patients and their carers in a kind and helpful manner.

The general environment was clean and tidy. There was level access to the practice allowing wheelchair users or those with mobility issues to access the facilities easily. The waiting room was spacious and the treatment areas were all situated on the ground floor.

All patents who responded to the questionnaire rated the service as 'very good' or 'good' and commented positively in the questionnaire.

This is what we recommend the service can improve:

- Forwarding all documents electronically to ensure there is an audit trail.

This is what the service did well:

- Signposting patients through health promotion material and the availability of various services
- Staff worked well together within a close knot community
- Patient access to other disciplines such as mental health and physiotherapy
- Patient feedback was positive.

Delivery of Safe and Effective Care

Overall summary:
The team at the surgery were dedicated, hardworking and committed to providing patients with safe and effective care in an environment that was clean. All treatment rooms were of a good size and were well equipped.

Our review of patient medical records found these to be generally comprehensive, clear, and easy to navigate with appropriate Read coding.

Whilst areas of good practice were seen, we did identify a small number of issues in relation to the storage of clinical waste, disposal of expired items of sterile items and medication. These issues were dealt with under HIW's immediate assurance process.

Immediate assurances:

- There were expired items in the emergency equipment bag and doctors' medical bag
- There was not a robust system for the management of sterile materials
- The contents of the emergency equipment bag were incomplete
- There were no checks of the emergency equipment includes checking dates of the contents of the bag
- Clinical waste was not stored safely and securely in an area not accessible to patients.

This is what we recommend the service can improve:

- Keep records of the temperature checks of fridges
- Patient medical records need to record where the consultation took place
- Carry out regular IPC audits with actions that recorded and cleared.

This is what the service did well:

- Patient medical records were clear and comprehensive with relevant read coding generally
- There was a documented business continuity plan
- Management of patients in mental health crisis.

Quality of Management and Leadership

Overall summary:
We found the quality of management and leadership at the surgery to be robust with clear reporting lines and a dedicated and committed practice management and senior team.

Staff discussion, although regular, was almost solely informal in nature.

The practice policies and procedures were stored on a shared drive accessible to all staff and were all in date with named staff responsible for amending these documents.

There were issues relating to the lack of basic life support training for the majority of staff. These issues were dealt with under HIW's immediate assurance process.

Immediate assurances:

- The majority of staff were out of date with training in basic life support and medical emergencies appropriate to their role.

This is what we recommend the service can improve:

- Provide job descriptions relevant to the role of staff
- Introduce a formal feedback process
- Staff mandatory training compliance
- Practice nurse supervision.

This is what the service did well:

- Managing the complaints process
- Policies and procedures were up to date
- The practice worked closely within the local cluster.

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

3. What we found

Quality of Patient Experience

Patient Feedback

Before our inspection we invited the practice to hand out HIW questionnaires to patients to obtain their views on the service provided at the practice. On the day of the inspection our inspectors also spoke with patients to find out about their experiences at the practice. In total, we received 23 responses from patients at this setting. Responses were positive across most areas, with all rating the service as 'very good' or 'good'. Patient comments included the following:

> *"I find the service especially great at all times. No complaints at all."*
>
> *"Lovely receptionist so helpful, supportive and friendly. Credit to the surgery."*
>
> *"Staff are always polite, friendly and helpful."*
>
> *"Very friendly staff with very good professional attitude, always helpful."*

Person centred

Health Promotion
There was sufficient information on display at the practice to ensure that patients who used the service were able to access information to help promote their health, improve their health and lead a healthy lifestyle.

We were also told that a mental health worker attended the practice once a week, this was in addition to any referrals made to secondary care and the signposting given to patients. In addition, patients could self-refer to physiotherapy and smoking cessation advice was available.

The practice was in the process of planning to manage the vaccination programme during the winter, with evening and Saturday clinics being planned. The practice had also engaged with the health board on the possibility to carry out COVID-19 boosters this autumn, at the practice.

The process at the practice to review patients who did not attend their practice appointments was that if the patients was vulnerable such as children or patients with dementia, the patient or their carer would be contacted by phone. We were also told that the practice did not follow up with patients who did not attend for hospital appointments unless they were vulnerable patients.

All the patients agreed that there was health promotion and patient information material on display.

Dignified and respectful care
We noted that the environment and practices of the organisation supported the rights of patients to be treated with dignity and respect. There were privacy curtains and lockable doors in the consultation rooms, along with level access to the property and the waiting room was spacious. Whilst conversations could be overheard when patients were at the reception desk, a room would be made available should the need arise. During our time at the practice, we only noted patients confirming their attendance to reception staff and not discussing any confidential matters.

All bar two patients who completed the questionnaire agreed that they were able to talk to reception staff without being overheard.

We were told that the practice offered chaperones in all appropriate circumstances and that all staff were trained and that the general practitioner (GP) was keen to use a chaperone when there was any doubt. We also saw the policy relating to chaperones that was in date and appropriate.

All of the patients who answered the questionnaire:

- Felt they were treated with dignity and respect
- Said measures were taken to protect their privacy
- Were offered a chaperone (for intimate examinations or procedures).

Timely

Timely Care
There were processes in place to ensure patients could access care via the appropriate channel in a timely way, with the most appropriate person. Patients could either telephone the practice or visit the practice in person to arrange an appointment. The reception staff would carry out relevant care navigation for the GP to triage. We were told that around 30-40% of patients were seen on a face-to-face basis. There was a good ratio of doctors to patients, which meant there was

seldom any long wait after the initial call was answered. The process for deciding which patients were seen face to face and those that were not, was decided at the initial call with the GP.

We were told that patients would always be seen face to face on request. Should a patient telephone the practice requiring urgent help, when all appointments were taken, an extra appointment would be created. To date, this had never been necessary as there were always sufficient appointments to meet demand. As with adults, children who required an urgent appointment would be seen following an initial assessment by telephone consultation with the parent followed by an appointment if requested or clinically indicated. There was clear safety netting advice documented in notes and patients would be reviewed by the practice or during out of hours as appropriate.

For patients requiring urgent mental health support or who were in crisis, following triage this would be followed by a face-to-face assessment if the referral to mental health services was considered likely. This would be by letter or telephone referral according to the urgency. We were told that response times were generally good with under 48 hours for urgent cases, they may occasionally need chasing if the patient condition worsened.

The practice was made aware when a patient had received crisis intervention for mental health needs by email following the initial assessment. The GP would then re-evaluate and re-contact if the situation deteriorated.

There were clear processes in place to ensure patients could access care via the appropriate channel in a timely way, with the most appropriate person. Due to the ratio of clinicians to patients this meant that patients could be spoken to and seen in a timely manner. This also ensured a prompt response to patient need.

We also noted a close working relationship between all staff to ensure that patients were always aware and offered the best options. The practice also provided or had access to a cluster pharmacist and mental health support one day a week. The cluster nurse visited housebound patients. The practice also provided access to a care and repair Cymru team that included occupational therapy, benefit advice, repairs, falls prevention and carer support

Percentages of patients who answered the various questions positively were as follows:

- Able to get a same-day appointment when they need to see a GP urgently - 87%
- They could get routine appointments when they need them - 91%

- They were offered the option to choose the type of appointment they preferred – 100%
- Content with the type of appointment offered - 95%
- They knew how to access out of hours services if they needed medical advice or an appointment that could not wait until the GP opening hours- 91%.
- The patients who said if they had an ongoing medical condition, they were able to access the regular support needed - 82%
- Provided with enough information to help them understand their health care – 100%
- They were satisfied with the opening hours of the practice were able to contact their GP practice when they need to – 91%.

Two comments were given about accessing the GP:

> *"Prefer face to face easier to exam and talk about problems.*
>
> *"Amazing staff very accommodating"*

Equitable

Communication and language
We were told that for patients with specific needs the practice would work around their ailment to make sure the surgery was quiet, for example for autistic patients when they came in and did not have to wait too long. We saw that the system used to record patient notes at the GP flagged those patients that were hard of hearing or deaf.

There were some bilingual (English and Welsh) signs, posters and reading material available. There were no Welsh speaking staff at the practice. Only one patient stated that Welsh was their preferred language and they stated that they were not actively offered the opportunity to speak Welsh during their patient journey and that healthcare information was not available in Welsh. Whilst there were no easy reads documents on display, we were told that these could be sourced if required.

The practice informed patients when their systems changed, by face to face or verbal contact, the practice would not use text messages or send emails.

We were told that patient capacity needs were assessed on initial registration and then were re-assessed if the patient capacity changed or where this was raised by secondary care or family members.

Information received from secondary care was reviewed to see how this was recorded and acted upon appropriately. We noted that letters arrived at practice by post, fax or e-mail. Electronic communications were printed off and all hard copies were given to the GP for comment and action. Any that had action notes were scanned back into the system and the actions carried out. There were no major problems with this method of management of letters and results, although the system used caused a loss of administrative time due to printing and rescanning of documents. Additionally, the audit trail would be manual and not electronic.

The practice should consider using the functionality of the electronic medical records system to forward the documents instead of printing the documents to ensure that there is an audit trail on the system of the GPs comments on the letters and results.

All communications were recorded in the patient record system. There would be an audit trail and anyone in the team would be able to understand the result of the discharge and future care for the patients. The information given to patients about their condition, investigation and management options so that they can understand their own health and illness was recorded in free text, which was not auditable.

The practice should consider using a Read code to record when patients have been given information to help them understand their own health and illness.

Patients would be contacted following discharge from secondary care if the GPs agreed further action was needed. There was not a formal system for identifying non-conformance with this, but as this was a small practice where staff usually knew patients personally and would chase up on patients who did not attend (DNA).

The service provided information to patients and communicated in a way that was clear, accessible and in a language and manner appropriate to their individual needs to enable them to make informed decisions about their care. Patients were informed in the recorded message that all calls were recorded. We also noted that the message included an introduction that included reference to COVID-19 which should be reviewed as it is now out of date and extended the message unnecessarily.

Requests for home visits were put on the GP list and triaged, this may then be passed to the cluster-based community nursing team depending on need. The practice ensured that communications had been read and acted upon as it would be logged against each message and was auditable.

There were systems in place for informing the practice of patients who were admitted to hospital via the Welsh clinical portal. Similarly, there were systems to alert the out-of-hours services or duty doctor to patients receiving end of life care, and for alerting the practice team when a patient had passed away.

All patients agreed that the GP explained things well to them and answered their questions and that they were offered healthy lifestyle advice, and most of the patients who answered felt staff listened to them. Most patients agreed that their appointments were on time and that their identity was checked. All bar one patient said that their medical details were checked, such as allergies and long-term conditions, before medication was prescribed and all patients said that they were given enough time to explain their health needs.

Rights and Equality
There was evidence that the practice culture and processes supported a service approach that recognised the diversity and rights of the individual. Staff we spoke with described the setting as a close-knit family like practice with each member of staff looking after each other.

Staff provided examples where reasonable adjustments were in place or made, so that everyone, including individuals with particular protected characteristics, could access and use services on an equal basis. This included adjustments where necessary for patient and staff, including support to staff who have been on sick leave, pregnancy and adjustments from DSE assessments. Patients would also be provided with later day appointments and longer appointments where needed.

Regarding transgender patients, the patient record system would include a message listing the patients' "known as" name.

All patients who completed the questionnaire stated that they could access the right healthcare at the right time. (Regardless of your Age, Disability, Gender reassignment, Marriage and civil partnership, Pregnancy and maternity, Race, Religion or belief, Sex and Sexual orientation). Most of the patients who answered felt involved in decisions about their healthcare.

Delivery of Safe and Effective Care

Safe

Risk Management
The practice was generally clean and sharps containers were securely fixed and not overfilled, all were signed and dated.

The practice had a Business Continuity Plan (BCP), but this may need to be reviewed as it was written during COVID-19 but was still relevant in many areas. The BCP adequately covered the business partnership risks. There were buddying arrangements in place with a nearby practice. The practice could still be considered as vulnerable as there were only two GP partners. Staff were aware of the BCP and a copy of the plan was available on the practice shared drive or as a printed copy.

There was also a sustainability framework in place that linked to the primary care information portal and listed various escalation levels.

The practice had a clear process for patient safety alerts with a dedicated member of staff responsible for receiving these. The alerts would be circulated by paper or by email.

Learning from patient safety incidents would be shared via email and significant events would be reviewed and discussed by the practice at staff meetings.

Regarding home visits, when the call is received for a home visit, it was passed to duty doctor for triage and further action. We were told that there was not a formal policy in place regarding home visits and that a medical assessment of need for personal protective equipment would be carried out during the triage. Gloves and masks were available in the GPs car and gowns would be taken from the surgery.

Regarding the environment all patients agreed the building was accessible with enough seats in the waiting area. They also agreed there were toilet and hand washing facilities that suited their needs and that the practice was ‘child friendly’.

Infection, Prevention, Control (IPC) and Decontamination
The environment was generally clean, this included a hand sanitising station in the reception area, with appropriate hand hygiene facilities in clinical areas. However, during the inspection HIW found three full clinical waste bags outside of the female patient toilet in the waiting room area. These clinical waste bags were

accessible to patients. HIW were not assured that appropriate measures were in place for the safe storage of clinical waste material which could pose an immediate patient safety risk. This was dealt with by the HIW immediate assurance process.

There was a cleaning contract in place for the practice as well as an adequate cleaning schedule in line with All Wales guidance.

The practice had an infection control policy that had been reviewed and was up to date and there was an appointed IPC lead in the practice. There was also a practice lead for immunisations and vaccinations. Staff we spoke with were aware of the various leads and where to find the infection control policy. They also understood their role and responsibility in upholding IPC standards, this was evidenced through discussion with staff on PPE and hand washing.

The last infection control audit was undertaken at the end of February 2023. However, several audit questions had a negative response with no comments and no action plan to explain how the issues would be addressed.

The practice is to ensure that infection control audits are completed on a monthly basis. The results of these audits are made known to practice staff and the relevant actions from the audit are rectified to ensure full compliance at the next audit.

New starters were asked to demonstrate their vaccination status and asked to have outstanding vaccinations recommended for healthcare professionals. There was evidence on file that all relevant staff had hepatitis B immunisations. A central record of staff hepatitis B status was held as well as a system for monitoring that all relevant clinicians were up to date.

Whilst there was not a dedicated room if someone presented with a condition that required isolation, the patient would remain in that room which would then be deep cleaned once they had left.

We noted that disposable curtains used in consultation rooms did not have a date on them and there were no elbow taps in the consulting rooms. Additionally, we noted a pillow in one consulting room that was covered with a cotton pillowcase. The other rooms had disposable covers on the pillows.

The practice is to ensure that the date the disposable curtains are brought into use is recorded on the curtains and that they are replaced at least annually and sooner if they are soiled. Disposable pillowcases must also be used on all pillows in the consultation and treatment rooms.

All patients agreed with the questions asked regarding IPC. They agreed that there were signs at the setting explaining what to do if you are contagious, hand sanitisers were available and that healthcare staff washed their hands before and after treating them. All of the patients who answered thought the GP setting was 'very clean'.

There were ten patients who stated that they had an invasive procedure that included having bloods taken, an injection or a minor operation. They all agreed that staff wore gloves during the procedure, the syringe, needle or scalpel used was individually packaged or sanitised and that antibacterial wipes were used to clean their skin before the procedure.

Medicines Management

The process followed by the practice for repeat prescriptions included a request from the patient, the prescription would then be generated by administration and signed by the GP. The practice had access to a cluster pharmacist who reviewed the use of medication by patients.

Vaccines were kept in a dedicated vaccine fridge which was well organised with plenty of room for air to circulate. Vaccines were stored to ensure that the cold chain was maintained for all applicable vaccines and immunisations. Whilst we were told that the temperature would be monitored constantly when the practice nurse was in the room for four days a week, but this was not recorded anywhere. There was a data logger in place for recording temperature but staff were unable to download the information from the new information technology (IT) system installed two weeks prior to the inspection.

In the absence of a data logger, the practice is to ensure that the medication and vaccine fridge temperatures are recorded daily and documentary evidence of this check is kept. When the data logger is available the results of the data logger are to be printed weekly and a record of the printout kept on file.

During the inspection HIW found expired items present within the emergency equipment bag and doctors' medical bag, that had not been removed from use. In addition, there were items missing from the emergency equipment that should be present. HIW were not assured that the practice had in place a suitably robust system to ensure that expired items including sterile items and medications were removed from use in a prompt and timely manner. Failure to remove expired items may mean that they could be used by a clinician and cause patient harm or be ineffective in the event of a lifesaving emergency. This was dealt with under HIWs immediate assurance process.

There was not a formal system in place for replacing expired drugs, the practice nurse was aware of the expiry dates for those items kept in their room and orders as necessary. The practice did not hold large quantities of disposable equipment such as needles and syringes and the practice nurse believed they were all used before they could expire.

The practice must ensure that there is a formal process in place to ensure that the dates of all drugs are checked on a monthly basis (weekly for emergency bag drugs) and any out-of-date drugs are disposed of in the correct manner and a record of the disposal kept on file. The process should also include a record of the ordering of replacements of these drugs and records of when the drugs are received.

All practice staff knew where the emergency equipment was kept in the practice nurse's room and the location of the defibrillator.

Safeguarding of Children and Adults
The practice had appointed one of the GP partners as the safeguarding lead and all staff were aware of this.

Staff we spoke with said that a marker was attached to the patient record of the child if they were at risk and the marker would be removed when it was considered the child was no longer at risk. Similarly, the same action would be taken for vulnerable adults.

The practice is a small, community-based practice and staff had been in post for some time and knew their population well and they were aware of safeguarding issues in the community as well as looked after children.

We were told that there had been a lack of communication from health visitors who were no longer practice based.

The practice needs to continue to engage with the health board to ensure that there is a process in place to ensure regular communication between health board employed health visitors and the practice staff as soon as possible.

We were provided with a training matrix that administrative staff had received level one training on safeguarding children and adults, and clinicians had received level three training.

Management of Medical Devices and Equipment
There was a contract in place with an external company to carry out the portable appliance testing and calibration of medical devices and equipment. Clinical staff

were expected to check that any equipment they used was fit for purpose. However, there was not a checklist to document that this check had been completed. The equipment seen was in a good condition. There were also contracts in place for emergency repairs and replacement.

We noted that the relevant equipment in the GP's home visiting bag did not have PAT stickers to show that the items had been checked. There was also not a formal regular check of the GP's home visiting bag.

The practice is to ensure that a checklist is put in place to ensure that:

- **All equipment is thoroughly checked on a daily basis and evidence of this check is kept**
- **The contents of the GPs home visiting bag are checked on a weekly basis and evidence of this check is kept on file.**

The practice did not have the full range of equipment required in the event of an emergency at the practice or had not risk assessed the reasons for not including these items. This posed a potential risk to the safety and wellbeing of patients in the event of a patient emergency (collapse). This was dealt with under HIWs immediate assurance process.

Effective

Effective Care

All staff had been given care navigation training to enable them to ask appropriate symptoms to identify red flags.

There was a process in place for supporting patients who had contacted the practice in crisis, using the crisis team based at the secondary care for the area. This support was available via a referral to the dedicated crisis team. In the event of a patient visiting the crisis team, the practice would be sent an email that would be followed up by the practice with the patient. We were told that the practice was making plans to host a once-a-month clinic for people with substance misuse problems to prevent them having to travel to Bridgend.

Efficient

Services were available to provide the efficient movement through care and treatment pathways via the self-referral of patients for musculoskeletal problems to a first contact physiotherapist who held a clinic once a week. Additionally, patients could self-refer to podiatry service and they could also refer for weight management advice.

We were told there were alternative processes in place to avoid inappropriate hospital admission. The practice aimed to see all acute presentations on the day. The community cluster nurses visited housebound patients for chronic disease management which had been effective in putting in place interventions before a crisis point was reached. There was also the Healthy Homes Project - Care and Repair. The service provided a dedicated caseworker and occupational therapist linked with the GP surgeries in the cluster which the practice was part of. The service delivered an alternative, proactive model of care that focussed on early intervention and prevention.

We were told that there was also a chronic obstructive pulmonary disease (COPD) outreach team which worked well to prevent hospital admissions. Additionally, the practice nurse had a good working relationship with the cluster pharmacist which was particularly helpful when needing to swap a medicine which was unavailable. Staff also had a good relationship with the Care and Repair team which helped with adaptations to keep patients in their own homes for as long as possible.

Patient records
We checked a sample of eight patient medical records and overall, we noted that there were generally comprehensive clinical entries under appropriate Read coded headings. However, there was free text recording of reasons for starting medications that made this difficult to track when a clinical Read code had not been used to link the drug.

There was good recording of factual information but the nature and location of the consultation was not recorded. This made it difficult to establish the percentage of consultations which were telephone, face to face or home visits or to identify when or whether records of telephone consultations took place. Additionally, regarding medicines management, whilst there was free text recording of reasons for starting medications, this again made it difficult to check, when a clinical Read code had not been used to link the diagnosis to the medication given.

As regard the location of the appointment 18 patients said it was in person at the practice and five said it was by telephone.

The practice must ensure that the type and location of the consultation are recorded and that clinical Read codes are used to link the diagnosis to the medication given.

Quality of Management and Leadership

Leadership

Governance and leadership
The GP partners were responsible for clinical oversight in the practice. Clinical information was shared in the practice via the clinical and electronic systems for primary care. There was also evidence of clinical meetings and dissemination of clinical information. We were also told that significant events were discussed and there were regular discussions between staff.

The practice manager was responsible for the quality assurance and improvement framework (QAIF). The QAIF rewarded GP practices for the provision of quality care and helped to embed quality improvement into general practice. There was clear accountability with regards to improvements and service standards, with the practice manager being responsible for this.

There were operational systems and processes in place to support effective governance, leadership and accountability to ensure sustainable delivery of safe and effective care. All staff were clear about their roles, responsibilities and reporting lines.

We were told that staff meetings, prior to COVID-19 were normally held once a month, meetings were now bi-monthly. However, if there were any staff concerns then a meeting would be held. As the practice was small, there were often a number of verbal and face to face conversations with staff. Information would be shared with staff through email and verbally, with the relevant information stored on the shared drive.

The practice policies and procedures were stored on a shared drive accessible to all staff. The policies and procedures that we reviewed were all in date with named staff responsible for amending these documents. Any changes would be communicated by email or verbally.

Senior staff we spoke with described the main challenges and pressures being faced by the practice as the new GP contract opening hours, the volume of patients with increasing need for face-to-face appointments.

The practice should consider how it can adapt ongoing capacity to meet the demand posed by the increasing volume of patients and increasing need for face-to-face appointments.

Workforce

Skilled and enabled workforce

We spoke with staff across a range of roles working at the practice. It was clear that they were all knowledgeable of their roles and responsibilities and committed to providing a quality service to patients. The practice appeared to have sufficient staff to meet the demand of the patients.

During our inspection we requested details of mandatory staff training. From the information provided we identified poor compliance with mandatory resuscitation training. The information showed that, apart from three members of clinical staff, the remainder of staff were not up to date with basic life support (BLS) training, with the last training shown as taking place in 2020. However, we were told that face to face training in BLS has been booked for November 2023. HIW were not assured that staff had the required up to date skills to perform effective BLS resuscitation. This posed a potential risk to the safety and wellbeing of patients in the event of a patient emergency (collapse). This was dealt with by the HIW immediate assurance process.

We found some gaps in mandatory training for staff across all clinical and non-clinical roles. We raised this with the practice manager and they assured us that mandatory training compliance was a key priority and would be dealt with as soon as possible.

The practice must ensure staff are fully compliant with mandatory training.

Training needs for all staff would be identified from discussions with staff, normally during annual appraisals and revalidation.

There was a workforce plan in place to ensure there was always appropriate capacity and skill mix of competent staff available when required, which was continuously reviewed in the practice development plan.

Staff had recently received duty of candour training and all staff could approach the partners or the practice manager with any queries, if they felt a need. Staff we spoke with felt able to raise concerns safely.

We were provided with the job description for the practice nurse and noted that this job description was for a community nurse nota GP practice nurse. There was also no job description in the personnel file of the practice nurse.

The practice must ensure there are up to date and relevant job description are available for staff and kept on file.

There did not appear to be any regular supervision of the practice nurse to ensure that the patients the nurse is expected to see are appropriate and fall within her scope of practice.

The practice needs to ensure that the practice nurse only examines patients within their scope of practice. Furthermore, there needs to be regular monthly supervision of the practice nurse to ensure that the work allocated is within their scope of practice and that the action taken during the examination has been appropriate.

Culture

People engagement, feedback and learning
There were appropriate processes in place for reporting concerns. These were in line with the Putting Things Right (PTR) processes in the NHS. We viewed a complaints policy and procedure which contained all the relevant information. PTR posters were also clearly displayed in the waiting areas. We reviewed the practice's complaints file and saw that complaints were dealt with in a robust manner and in line with the agreed complaints timescales stated within the policy.

In all 82% of patients who completed the questionnaire knew how to complaint about their poor service.

We spoke with senior practice staff to understand the arrangements in place for compliance with the Duty of Candour requirements. The practice had a Duty of Candour policy that met the requirements of the guidance. This was clear and set out the roles and responsibilities of staff. Staff we spoke with understood the Duty of Candour and their roles in meeting this duty. We saw evidence that some practice staff had received training on the Duty of Candour and were assured that all staff were aware of how to raise a concern should something go wrong.

Senior staff at the practice were visible and approachable and they considered themselves to be a diverse organisation. Staff we spoke with had all signed up to the overall vision and values of the practice and were encouraged to speak up when they had new ideas or concerns. Staff were proud and happy to work at the practice.

Staff had access to "Mental Wellbeing at Work" should they need to use the facility.

We were told that staff feedback was sought in a variety of ways, mainly verbally. Ideas would be discussed at a practice level and changes made accordingly where appropriate.

The practice would verbally collect information to assess patient views.

The latest All Wales Clinical Governance Practice Self-Assessment Tool (CGPSAT) stated that the practice undertook routine surveys on a variety of subjects and that the practice has also participated in a number of surveys directed by the community health council which were carried out during visits to the practice. Patients also completed a questionnaire as part of this inspection and access surveys have also been undertaken as part of contract requirements and shared at cluster level. However, we were not shown any results of any recent patient feedback about the practice.

Only 29% of patients stated that they had been asked by their GP practice about their experience of the service they provided, with 48% disagreed.

The practice is to engage with patients on a regular basis to obtain formal feedback on the practice. The results of this feedback should be displayed in the practice on a "you said, we did board" or similar.

Information

Information governance and digital technology

There was secure storage or patient records that complied with The Data Protection Act 2018 which was the UK's implementation of the General Data Protection Regulation (GDPR). There were old paper-based records on site, which were mainly used to support report writing. There was also an effective records management system.

The practice manager was the data protection officer, supported by Digital Healthcare Wales. There were data protection and privacy notices available on the website. We were told that there were systems in place to ensure the effective collection, sharing and reporting of high-quality data and information within a sound information governance framework. This was evidenced in the access standards and the quality assurance and information framework (QAIF)

Datix (for incidents) were reported as necessary and all referrals were made in a timely manner as well as ensuring that any follow ups were actioned accordingly.

Learning, improvement and research

Quality improvement activities

The engagement of the practice in activities to continuously improve by developing and implementing innovative ways of delivering care was mainly carried out at a cluster level. The latest available delivery plan for the cluster made reference to the community practice nurse team working in the cluster had been essential in providing treatment to vulnerable housebound patients and in turn this had alleviated pressures on the district nurses.

Whole system approach

Partnership working and development
There was evidence of collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the population and to deliver services to meet those needs. This evidence included cluster working, partnership working with third sector such as Healthy Homes and other primary care services such as mental health and patient self-referrals.

We were told that the practice worked closely within the Bridgend North cluster to build a shared understanding of challenges within the system and the needs of the population. The practice manager was also the cluster lead and the cluster was very proactive in providing additional services for patients.

4. Next steps

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

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

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

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

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

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

Appendix A – Summary of concerns resolved during the inspection

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

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

Appendix B – Immediate improvement plan

Service: Nantymoel Surgery

Date of inspection: 3 August 2023

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

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
During the inspection HIW found expired items present within the emergency equipment bag and doctors' medical bag, that had not been removed from use. In addition, there were items missing from the emergency equipment that should be present. HIW were not assured that the practice had in place a suitably robust system to ensure that expired items including sterile items and medications were removed from use in a prompt	The practice is required to: • Ensure all expired items are removed from the emergency equipment bag and doctors' medical bag and disposed of in an appropriate manner • Develop, implement and maintain a robust system for the management of sterile materials • Ensure that the relevant items are included in the emergency equipment bag or a risk	The Practice will complete an audit of all doctor's medical bags and equipment to ensure compliance and standards are maintained. The Public Health Wales Quality Improvement toolkit will be used to assess each doctor's bag and all equipment and medications kept on the premises. The practice uses disposable items and we will ensure that any items that may be on the premises that would require sterilisation will be disposed of immediately.	Dr. Masroor Ahmed/Dr. Miti Khurana/ Jo-anne Williams/ Sarah Thomas	2 days (complete)

and timely manner. Failure to remove expired items may mean that they could be used by a clinician and cause patient harm or be ineffective in the event of a lifesaving emergency. Additionally, the practice did not have the full range of equipment required in the event of an emergency at the practice or had not risk assessed the reasons for not including these items. This poses a potential risk to the safety and wellbeing of patients in the event of a patient emergency (collapse).	assessment is carried out on not including the items • Ensure that the check of the emergency equipment includes checking dates of the contents of the bag with regular compliance audits taking place.			
During our inspection we requested details of mandatory staff training. From the information provided we identified poor compliance with mandatory resuscitation training. The information showed that no staff were up to	The practice is required to: • Develop, implement and maintain a mandatory training schedule to ensure staff are up to date with the requirements	A face-to-face session has been arranged for 21/11/2023 at the practice with St. John's ambulance. This will cover BLS, CPR and refresh training on the use of the defibrillator. Full certificates will be provided to all staff on	Sarah Thomas	End September 2023

date with basic life support (BLS) training, with the last training shown as taking place in 2020, however we were told that face to face training in BLS has been booked for November 2023. Following on from this we received subsequent confirmation that three of the clinical staff had completed the relevant training as part of their revalidation and were in date with this training. However, not all staff were up to date with BLS training. HIW were not assured that staff had the required up to date skills to perform effective BLS resuscitation. This poses a potential risk to the safety and wellbeing of patients in the event of a patient emergency (collapse).	• Ensure that all staff have appropriate training in basic life support and medical emergencies appropriate to their role • Provide HIW with evidence to support the BLS training undertaken by the clinicians • Ensure that training records are updated to include any training carried out as part of revalidation of clinical staff.	completion. Clinical staff complete an annual update and all staff will be asked to complete an on-line session before the face-to-face session arranged in November. All staff have been set up to ensure that they have access to appropriate e-learning Training records are maintained for all staff to ensure compliance with mandatory training and forms part of annual appraisal.		

During the inspection HIW found three full clinical waste bags situated outside of the female patient toilet in the waiting room area. These clinical waste bags were accessible to patients. HIW were not assured that appropriate measures were in place for the safe storage of clinical waste material which could pose an immediate patient safety risk.	The practice is required to: • Remove the clinical waste bags from the waiting room area • Ensure clinical waste is stored safely and securely in an area not accessible to patients.	This is an ongoing problem for the practice as we have very limited space and no designated waste holding area. There are plans to develop our site and we are working with our landlords and the local health board to achieve this. In the plans for development which have been drawn up there will be designated waste holding area included. For the short term we have purchased a secure lockable box which will be stored inside the building away from public access areas.	Sarah Thomas – Practice Manager, Asa Group – Landlords, Cwm Taf Health Board	1 week

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): **Sarah Thomas**

Job role: **Practice Manager**

Date: **9 August 2023**

Appendix C - Improvement plan

Service: Nantymoel Surgery

Date of inspection: 3 August 2023

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

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
Electronic communications were printed off and all hard copies were given to the GP for comment and action. Any that had action notes were scanned back into the system and the actions carried out.	The practice should consider using the functionality of the electronic medical records system to forward the documents instead of printing the documents to ensure that there is an audit trail on the system of the GPs comments on the letters and results.	The practice has been using the electronic workflow within our Docman system but had come away from it due to problems with the functionality of our IT systems and chronic internet speeds. We have been upgraded and are now using electronic workflow wherever possible.	Sarah Thomas	September 2023 - ongoing
The information given to patients about their condition, investigation and management options so that they can understand their own health	The practice should consider using a Read code to record when patients have been given information to help them understand their own health and illness.	When information leaflets are generated within the clinical system this is automatically coded into the medical notes. However, we have many other information leaflets including	Dr Masroor Ahmed Dr Miti Khurana Jo-anne Williams Sarah Thomas	06/10/2023 - ongoing

and illness was recorded in free text, which was not auditable.		self-referral information which will need to be manually recorded in the records. This has been put in as free text as mentioned and we agree that auditing would be difficult. Going forward we will be using Read codes starting 8CE, there are a range of codes covering multiple chronic conditions. We will use code 8CE – self help advice leaflet given which is the nearest code we could use if there is no direct match for the information provided.		
The last infection control audit was undertaken at the end of February 2023. However, several audit questions had a negative response with no comments and no action plan to explain how the issues would be addressed.	The practice is to ensure that infection control audits are completed on a monthly basis. The results of these audits are made known to practice staff and the relevant actions from the audit are rectified to ensure full compliance at the next audit.	Going forward the practice will conduct a monthly infection control audit. The development of practice premises has been agreed and this will support us with compliance, especially in relation to waste holding. All clinical staff will be involved	Dr. M. Ahmed Dr. M. Khurana Jo-anne Williams Sarah Thomas	Ongoing

		in reviewing infection control procedures.		
We noted that disposable curtains used in consultation rooms did not have a date on them and there were no elbow taps in the consulting rooms. Additionally, we noted a pillow in one consulting room that was covered with a cotton pillowcase. The other rooms had disposable covers on the pillows.	The practice is to ensure that the date the disposable curtains are brought into use is recorded on the curtains and that they are replaced at least annually and sooner if they are soiled. Disposable pillowcases must also be used on all pillows in the consultation and treatment rooms.	We have now dated the curtains and the cotton pillowcases have been removed and all replaced with disposable cases. We have arranged for elbow taps to be installed as part of the practice development.	Jo-anne Williams Sarah Thomas	31 October 2023
Whilst we were told that the temperature would be monitored constantly when the practice nurse was in the room for four days a week, but this was not recorded anywhere. There was a data logger in place for recording temperature but staff were unable to download the information from the new information technology (IT)	In the absence of a data logger, the practice is to ensure that the medication and vaccine fridge temperatures are recorded daily and documentary evidence of this check is kept. When the data logger is available the results of the data logger are to be printed weekly and a record of the printout kept on file.	The practice has a data logger for the fridge, however the software had to be re-installed following the computer refresh which had recently taken place in the practice. The software is now installed on the PC in the treatment room and the data logger is being used to record fridge temperatures.	Jo-anne Williams Sarah Thomas	Completed

system installed two weeks prior to the inspection.				
There was not a formal system in place for replacing expired drugs, the practice nurse was aware of the expiry dates for those items kept in their room and orders as necessary. The practice did not hold large quantities of disposable equipment such as needles and syringes and the practice nurse believed they were all used before they could expire.	The practice must ensure that there is a formal process in place to ensure that the dates of all drugs are checked on a monthly basis (weekly for emergency bag drugs) and any out-of-date drugs are disposed of in the correct manner and a record of the disposal kept on file. The process should also include a record of the ordering of replacements of these drugs and records of when the drugs are received.	All items required have been ordered and are in the practice. Emergency drugs kept in the treatment room are checked weekly. During the visit the practice did not have glucogel, this had been ordered through the local pharmacy and unfortunately, as there was a supply problem we had to wait for stock, this is now at the practice. The doctor's bags have been audited in line with the Quality Improvement Toolkit (PHW) and items ordered to ensure stocks are up to date. Disposal of out-of-date medications are completed in line with requirements. The Doctors will be completing weekly checks on their bags and any items required will be	Dr. M. Ahmed Dr. M. Khurana Jo-anne Williams Sarah Thomas	Completed 17/08/2023

		ordered by the Practice Manager.		
We were told that there had been a lack of communication from health visitors who were no longer practice based.	The practice needs to continue to engage with the health board to ensure that there is a process in place to ensure regular communication between health board employed health visitors and the practice staff as soon as possible.	This had been an issue at due to staff shortages within the Health Visiting Department. Different Health Visitors were attending each baby clinic and there was lack of continuity which was outside of our control, however we have always maintained good contact with the Head of the Health Visiting Team who is well known to the Practice. We are pleased to confirm that the practice has now been allocated a regular Health Visitor who is attending the practice baby clinic every week on Tuesdays and is working very well with practice staff.	Cwm Taf Health Board Dr. M. Ahmed Dr. M. Khurana Jo-anne Williams Sarah Thomas	Completed (05/09/2023)
Clinical staff were expected to check that any equipment they used was fit for purpose. However, there was not a	The practice is to ensure that a checklist is put in place to ensure that:	We have a full check list and a contract for annual pat testing and calibration with Williams	Dr. M. Ahmed Dr. M. Khurana Jo-anne Williams	Ongoing – formal process to be

checklist to document that this check had been completed. We noted that the relevant equipment in the GP's home visiting bag did not have PAT stickers to show that the items had been checked. There was also not a formal regular check of the GP's home visiting bag.	• All equipment is thoroughly checked on a daily basis and evidence of this check is kept • The contents of the GPs home visiting bag are checked on a weekly basis and evidence of this check is kept on file.	Medical. The file is located in the Practice Manger's office. The equipment in the Doctors bag is also checked however the item in the bag at the time was new and will be checked as part of our annual audit. All equipment is checked before being used and we will discuss ways of how these additional daily checks should be recorded and how they can be effectively carried out by a designated staff member. We have not established a formal record for equipment checks on a daily basis but can confirm that all equipment is checked weekly. Any equipment that is found to be faulty or not working is replaced as required.	Sarah Thomas	established by 30/11/2023
The nature and location of the consultation was not recorded. This made it difficult to establish the percentage of	The practice must ensure that the type and location of the consultation are recorded and that clinical Read	This has become an issue since the pandemic and the introduction of more remote working. All clinical staff are	Dr. M. Ahmed Dr. M. Khurana Jo-anne Williams	Ongoing

consultations which were telephone, face to face or home visits or to identify when or whether records of telephone consultations took place.	codes are used to link the diagnosis to the medication given.	reminded that it is essential that data entry is accurate and the need to ensure the right code for consultation is used. In addition, this is essential for the GP activity data we are collecting which needs to reflect the workload currently facing primary care. Face to face appointments have increased when compared to remote consultations and we are ensuring the appointment booking screen in the clinic system indicates the nature of the consultation to support accurate collection of data.	Sarah Thomas	
Regarding medicines management, whilst there was free text recording of reasons for starting medications, this again made it difficult to check, when a clinical Read code had not been used to link		This is a widespread issue in primary care especially when medications on newly registered patients are added or transferred via GP2GP. There is a reliance on accurate data being entered by previous practices which is often difficult to establish	Dr. M. Ahmed Dr. M. Khurana Jo-anne Williams	Ongoing

the diagnosis to the medication given.		when waiting for records to be transferred. As part of medication review clinical staff will be tidying up data to link items prescribed to problems.		
Senior staff we spoke with described the main challenges and pressures being faced by the practice as the new GP contract opening hours, the volume of patients with increasing need for face-to-face appointments.	The practice should consider how it can adapt ongoing capacity to meet the demand posed by the increasing volume of patients and increasing need for face-to-face appointments.	We have been participating in the enhanced service for additional capacity for just over a year and it has proved to be very beneficial to patients and has helped to alleviate pressures on staff. We have employed a practice nurse to work in the evenings on four days each week. This provides patients with more access for chronic disease clinics, immunisations and minor illness appointments. During the flu season we will be offering last evening appointments for immunisation which will provide patients who are working with more flexibility and carers will also have more	Dr. M. Ahmed Dr. M. Khurana Sarah Thomas Clive Gillard-Sage	Ongoing with regular review with reference to the patient access survey and other patient feedback

		opportunity to attend. We have increased access options and patients often prefer telephone consultation which we continue to offer when appropriate. Limited access to minor ailment support with local pharmacy is a problem for us and we are hoping to see improvements in this service as time goes on. In view of the ongoing increase in patient demand we will be continuing with extra capacity for the foreseeable future.		
We found some gaps in mandatory training for staff across all clinical and non-clinical roles. We raised this with the practice manager and they assured us that mandatory training compliance was a key priority and would be dealt with as soon as possible.	The practice must ensure staff are fully compliant with mandatory training.	Access to training has been difficult throughout the pandemic and NHS e-learning site performance and course availability does not always meet the needs of primary care. (Please note that we do not have access to ESR which is used by the trust). To address this issue, we have access to Practice Index which provides a comprehensive e-learning	Sarah Thomas (Lead) All staff	Ongoing – completion expected by end of February 2023

		portfolio which is specifically tailored to meet the needs of primary care. Mandatory training and other useful training courses are offered which is funded by the practice for an annual fee. Staff have access and we are undertaking training when we can spare time and staff to complete. It is difficult to release everyone especially when we have very limited protected time for training. On 21st November '23 we have arranged a face-to-face CPR and life support course including the use of defibrillator with St. Johns Ambulance, our training expired at the end of February 2023 and this was the first session that we could get on a protected learning day. In the meantime, staff have completed the basic life support course as shown on the certificates forwarded.		

We were provided with the job description for the practice nurse and noted that this job description was for a community nurse nota GP practice nurse. There was also no job description in the personnel file of the practice nurse.	The practice must ensure there are up to date and relevant job description are available for staff and kept on file.	The practice has reviewed job descriptions for all staff, and these have been implemented. Job descriptions are reviewed as required and discussed with staff as part of appraisal for personal development and training needs.	Dr. M. Ahmed Dr. M. Khurana Sarah Thomas	Completed
We were not shown any results of any recent patient feedback about the practice.	The practice is to engage with patients on a regular basis to obtain formal feedback on the practice. The results of this feedback should be displayed in the practice on a "you said, we did board" or similar.	The practice participates in the annual survey as directed from Welsh Government as well as other surveys which are relevant. During the next year we will be completing a survey in relation to digital services, access and surveys will take place for our clinical staff as part of appraisal. We have displayed information in the past regarding survey outcomes, but these had been removed at the time of the visit as they had been on display for a number of months. We display our GP	Sarah Thomas	Survey due to begin December '23

		activity data, which is updated monthly, and we will publish results on our next surveys when available.		
There did not appear to be any regular supervision of the practice nurse to ensure that the patients the nurse is expected to see are appropriate and fall within her scope of practice.	The practice needs to ensure that the practice nurse only examines patients within their scope of practice. Furthermore, there needs to be regular monthly supervision of the practice nurse to ensure that the work allocated is within their scope of practice and that the action taken during the examination has been appropriate.	We can confirm that any patients booked for nurses can be referred back to GPs if it is felt that treatment needed is outside of their scope of practice. The doctors are available to support the practice nurses during clinics and will provide support and consultations to patient as required when they are attending appointments with the nurses. All reception staff have completed care navigation training to support them in managing patient requests and allocating them to the appropriate clinical staff. We discuss these issues as needed and patient appointments and allocations	Dr. M. Ahmed Dr. M. Khurana Jo-anne Williams Sarah Thomas	Ongoing

		are reviewed as part of our access arrangements.		

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): Sarah Thomas

Job role: Practice Manager

Date: 10th October 2023