Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Llantwit Major and Coastal Vale Medical Practice - Eryl Surgery, Cardiff and Vale University Health Board

Inspection date: 5 September 2023

Publication date: 13 March 2024

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Digital ISBN 978-1-83577-805-0

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 Llantwit Major and Coastal Vale Medical Practice - Eryl Surgery, Cardiff and Vale University Health Board on 5 September 2023.

Our team for the inspection comprised of two HIW Healthcare Inspectors, two clinical peer reviewers and a practice manager 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:
Nearly all the patients who completed a HIW questionnaire rated the service provided by the practice as 'very good' or 'good'.

The practice was committed to providing a positive experience for patients and we heard and saw staff greeting patients in a polite and friendly manner both on the telephone and at the practice. This approach was also evidenced via the positive results in the annual GP survey that was conducted by the NHS.

We noted good arrangements to support patients with mental health concerns and in ensuring that all children under 16 were offered a face-to-face appointment.

There were systems and processes in place to ensure patients were being treated with dignity and professionalism.

There was good accessibility for all patients, with ground floor access, as well as a disabled toilet and parking directly outside the main entrance.

This is what we recommend the service can improve:

- Put arrangements in place to provide an effective 'Active Offer' to patients.

This is what the service did well:

- Patient feedback survey was positive
- Dedicated staff providing good patient care
- Using a variety of methods to communicate with patients
- Elderly patients would be offered a face-to-face consultation as were children under 16 years old
- Good support for patients with mental health issues.

Delivery of Safe and Effective Care

Overall summary:
The practice was well maintained and equipped to provide the services they delivered. All areas were clean and free from any visible hazards.

The sample of patient records we reviewed were of a good standard. However, the records would benefit from clinical Read codes being used more to link entries and diagnoses.

Whilst there was good checking of emergency drugs and fridge temperatures, the room temperature needed to be monitored for the dry store containing certain medications and the emergency drugs.

Immediate assurances:

- We identified several issues relating to infection prevention and control, these included:
  - Clinical curtains used to provide privacy, had not been changed in some instances since 2017
  - Items of Personal Protective Equipment (PPE) that were unprotected from airborne contamination
  - Posters and information displayed on noticeboards had not all been suitably laminated
  - No evidence of audits of IPC and hand hygiene
  - We were not assured that all staff at the medical practice had in place a suitable level of IPC training appropriate to their role.

This is what we recommend the service can improve:

- Room temperature monitoring
- Improve use of Read codes.

This is what the service did well:

- Individual patient records were good
- Good checking of emergency drugs and fridge temperatures
- Clinical rooms were spacious and uncluttered.

Quality of Management and Leadership

Overall summary:
The practice appeared to be well managed by a committed and dedicated practice manager who was open and approachable, which enabled staff to be confident to raise issues.

The practice also had a comprehensive register of policies in place. All were easily accessible for staff through a shared drive.

Some issues were raised which needed to be addressed.

This is what we recommend the service can improve:

- Inform patients of the changes made as a result of patient feedback.

This is what the service did well:

- Staff were eager for the practice to succeed and offer patients a supportive service
- Policies in place were well written, clear and available to all
- Good complaints management.

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. In total, we received 23 responses from patients at this setting. Some questions were skipped by some respondents, meaning not all questions had 23 responses. All respondents who provided comments agreed they could be published anonymously within the HIW inspection report.

Responses were positive across most areas, with all but two respondents rating the service as 'very good' (11/22) or 'good' (9/22). Some of the comments we received about the service and how it could improve are below:

> ***"This GP practice has been excellent for myself and my family."***
>
> ***"I have been at the practice for 26 years, always great service."***
>
> ***"I have had issues in the past with communication with tests and referral times."***
>
> ***"The amount of time given daily to make a same day appointment is poor. I assume there are not enough doctors available to see the amount of patients needing same day treatment."***

Person centred

Health Promotion
Based on the information seen, patients who used the service were able to access information to help promote their health, improve their health and lead a healthy lifestyle.

There were health promotion leaflets displayed on maintaining a healthy lifestyle, including smoking cessation, the practice also used social media to inform patients. The practice had contacted various organisations such as Age Concern and Macmillan for leaflets to display at the practice. There was a television in the

waiting room that contained relevant information for patients as well as on notice boards.

The practice was able to signpost patients to the mental health practitioner within the cluster. There was also an office of MIND next door to the practice and a number of referrals were made to them. Whilst patients could not self-refer to the physiotherapist, they could be referred to the cluster-based physiotherapist by the practice.

Staff we spoke with described the processes adopted by the practice and cluster to work with other agencies, such as voluntary agencies, community groups and local authorities. These included Madeleines dementia project, care at home project and the practice had set up a virtual ward round with social services.

There was a process in place to monitor and record instances where patients did not attend hospital appointments. Staff said there was not an issue with patients who did not attend for appointments, nurses would follow up on these, particularly when the appointment was for a child.

All bar one patient said on the questionnaire that there was health promotion and patient information material on display.

Dignified and respectful care
The environment and practices of the organisation supported the rights of patients to be treated with dignity and respect. Staff we spoke with were dedicated to providing good patient care within a friendly practice. The clinical rooms gave patients appropriate levels of privacy, doors were closed during consultations and there were privacy curtains in the consulting rooms viewed.

Whilst the reception areas appeared to give patients the appropriate levels of privacy, only 39% of patients agreed that they were able to talk to reception staff without being overheard, 61% disagreed. There was also a room next to reception that could be used to discuss any issues with patients. However, during our inspection we noted that the room also contained patient information including patient letters. This room should not be used if there is any personal information on display nor if the patient is left unattended in the room. Senior staff stated that it was their process to remove the portable in-trays to create a confidential space and that personal information would not be on display.

The practice is to continue to ensure that the room used to speak to patients in private is cleared of any personal information and that any information kept in the room is kept secured.

There were automatic doors and level access to the practice with several consulting rooms located on the ground floor that provided easy access for wheelchairs and people with mobility issues. There were good facilities noted at the practice including spacious consultation rooms, inside a new building, with a large conference room. The waiting room was bright and airy. The practice had a community feel; the staff knew their patients well.

Whilst there was evidence that chaperones were offered to patients at the practice, there were no male chaperones available. Male patients who required a chaperone were offered a female chaperone. Patients were aware that chaperones were available if required and there was a chaperone policy available for staff. The training for chaperones was completed during the induction process by video and also at the practice. We were told that the practice followed the guidance and recorded verbal consent for intimate examinations and requests for chaperones in patients' notes. All patients who completed the questionnaire and who needed an intimate examination or procedure, confirmed they were offered a chaperone.

All patients who answered the questionnaire felt they were treated with dignity and respect and most of the patients said measures were taken to protect their privacy. All of the patients felt the GP explained things well and answered their questions and all but one felt involved in decisions about their healthcare. Some comments we received about patient care were:

> ***"Rudely spoken to by receptionist. Doctor asked me what I wanted to do re. medication - I have not had medical training and rely on doctor to advise. Feel I am not being listened to re. an ongoing issue."***

> ***"Medical staff work extremely hard but surgery is not directly accessible to patients..."***

Timely

Timely Care

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. The access arrangements for patients were described, these included electronic mail, My Health Online, telephone or direct presentation at reception. We were told that there would be same day telephone triage with a follow up either, face to face, a home visit and an appointment or referral as indicated by the triage. The practice aimed to accommodate patient requests to be seen. If there were no appointments available on the day, extra appointments would be offered when needed. The protocol on reception was that all children under 16 were offered a face-to-face appointment.

We noted that the telephones were answered promptly at the practice and there were not lengthy delays noted. The practice website also contained information on the results of the annual GP survey conducted by the NHS. This showed that 87% of patients felt that the time they waited was about right

For patients requiring mental health services, following telephone triage the patient would be signposted to the health board mental health support worker, MIND or a face-to-face appointment according to need. We were told that the practice was in a small community where the GPs were aware of patient needs.

Staff we spoke with said that it was easy to contact the practice and patients could also contact the practice through an online application. We were told that all staff handled calls in the morning to ease the process of contacting the practice via the telephone in an acceptable timeframe.

Staff involved in care navigation had a clear pathway, which was documented in a reception training manual. Staff had also received training from Health Education and Improvement Wales (HEIW). Non-clinical staff involved in triaging would be supported by clinical staff where necessary.

Relating to access to their GP, 82% of patients answered in the questionnaire that they were satisfied with the opening hours of this practice and 74% were able to contact their GP practice when they needed to. All patients agreed they knew how to access out of hours services if they needed medical advice or an appointment that could not wait until GP opening hours. Over three quarters of those were seen in person, the remainder by telephone or text. For those patients with an ongoing medical condition, 73% said it was ‘very easy’ or ‘easy’ to access the regular support needed, but the other 27% said it was ‘not easy’ or ‘not very easy at all’.

Equitable

Communication and language
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.

The practice had a practice leaflet describing the services available, this information was available in alternative formats such as large print. We noted that the smear test information was also in an easy read format. Where necessary messages would be sent to patients via text messaging and email. Where patients did not have mobile contact details, they would be contacted by letter. Letters would also be sent to certain demographics, such as the elderly or those with

memory issues. For patients that were digitally excluded we were told that elderly patients would be offered a face-to-face consultation.

A range of comprehensive information was also available on the practice website. This provided an option for patients to access information.

The practice would inform the patients when their systems changed by a variety of methods, including a message on the recorded telephone message when patients were awaiting connection. There would also be notices on the notice board and the television screen in reception.

We were told that the practice would always check for third party consent and if a relative or carer had power of attorney, this would be flagged on their patient records. Staff stressed that they always made sure that the patient could understand what was happening to them. There was a clear, well written access policy and a consent policy in place, which were in date.

Where a translation service had to be used for patients who could not speak English, we were shown examples of where the patients were given a double appointment slot to account for the extra time taken. Some staff had also completed dementia awareness training.

Written information displayed in the practice was generally available in English only. We were told there were no Welsh speaking staff working at the practice currently. Where required, we were told staff could access a translation service to help them communicate with patients whose first language was not English. Staff understood the importance of speaking with patients in their preferred language supporting the delivery of good healthcare. Two patients who completed the questionnaire said they were Welsh speakers.

The practice must put arrangements in place to provide an effective 'Active Offer' to patients and expand the selection of information available, taking into consideration the communication needs and wishes of patients using the service.

We checked a sample of five results from secondary care and five outpatient letters to ensure they were recorded and acted upon appropriately. We found that letters to the practice were triaged by trained administrative staff and sent to a summariser, pharmacy technician (medication) and the referring or responsible doctor, if actions were required. This would be recorded in the patient notes.

Where an incoming result or report of an investigation required follow-up, the practice used workflow to communicate results. This included informing relevant

team members involved when patients were discharged from hospital. 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 has died.

If there were any further actions required by the practice, following discharge from secondary care, this would be communicated to the patient by direct contact such as letters, text message or telephone call, often by the doctor.

Rights and Equality
It was positive to note that the organisation's culture and processes supported a service approach that recognised the diversity and rights of individuals. We found that good, positive adjustments were made for patients.

Staff we spoke with were able to describe how equality, diversity and inclusion was promoted within the organisation. There was a policy in place and staff had completed the 'Treat me Fairly' training. They stated that everyone was treated fairly and the practice made the necessary adjustments where required. Staff were able to speak to management if there were any issues. All patients would be treated the same irrespective of any characteristic. The practice provided examples of where this adjustment had taken place.

Patients would be asked how they wished to be addressed, including their preferred pronouns and the patient record would be updated accordingly.

Those patients requiring home visits were required to call before 10am and then they would go on a house call list, which was shared equally amongst GPs on a daily basis. The record of these consultations would be recorded in the patients' medical summary, when the doctor returned to the practice, so that all clinical staff were aware of any new diagnoses or changes to a patient's condition.

There were two questionnaires completed by those who provided care for someone with disabilities, long-term care needs or a terminal illness. Regarding whether the patient had been offered an assessment of their needs as a carer, one said yes, but both said the practice had given them details of organisations or support networks that could be provided information and support.

In the questionnaire, three respondents felt that they had faced discrimination when accessing or using this health service. Whilst one specific comment was made by a patient, as this may identify the patient, the comment has not been included.

When asked in the questionnaire about whether they could access the right healthcare at the right time, regardless of any protected characteristic, 73% agreed. Comments made included:

“Medical staff work extremely hard but surgery is not directly accessible to patients.”

“Doctor says make appointment, receptionist says no.”

The practice is to provide HIW with information about the efforts it has made and will continue to make to ensure patients are not discriminated against.

Delivery of Safe and Effective Care

Safe

Risk Management
There were clear processes in place to protect the health, safety and wellbeing of all who used the service. The practice was clean, with clear stairways and corridors.

There was appropriate signage to alert staff and patients of any dangers. There were reminders above the sink to remind staff and patients to handwash. Staff only areas were clearly marked, although the signage for navigation around the practice were not clear, especially considering the elderly patient demographic. However, fire exits were clearly marked.

The practice should ensure that the signage for navigation around the practice is clear, taking account of the patient demographics.

Sharps containers were securely fixed to the walls and none were seen overflowing in the consulting rooms inspected.

When the practice received a call for a home visit, this would be triaged by the nearest doctor and a visit arranged at the end of the day's surgery or sooner if urgent. A clinical decision would be made at the triage call if PPE was needed. The practice was responsible for one care home, which was visited regularly on a Tuesday. There were no risks found in this area.

The practice had a Business Continuity Plan (BCP), which covered the business partnership risk. The practice BCP included how to deal with any significant health emergency. The practice did not have any GP staff retention issues, some of the GPs were partners and some were salaried.

The GPs held an online meeting daily at 1 pm, to handover as required to the afternoon staff. We were told that trainee GPs had a hot review, so they were all part of the decisions.

The practices had a good, clear process for patient safety alerts. There was provision for making new starters and locums aware of patient safety alerts in the locum pack.

The practice carried out Significant Event Analysis as required within teams meeting, these would also be reviewed after six months to revisit and ensure learning was carried out where relevant.

The mechanism used for calling for help urgently within the practice was through the buttons on the computer system.

All patients who answered the question on the questionnaire agreed that the building was easily accessible, there were enough seats in the waiting area and that there were toilet and hand washing facilities that suited their needs. The majority of patients agreed the practice was 'child-friendly' (77%) the remainder said they did not know.

Infection, Prevention, Control (IPC) and Decontamination
We found some issues regarding the environment, policies and procedures, staff training and governance arrangements which meant that standards of IPC to protect patients, staff and visitors using the service needed to be improved.

The practice had placed a white, plastic bin outside of the building for the collection of patient clinical samples. This was not appropriately labelled in line with IPC guidelines regarding its contents and did not contain the appropriate clinical waste bag should the contents of the bin require disposal. Adjacent to the sample bin, was a set of plastic drawers. The contents included empty clinical sample collection pots and universal sample containers for patients to collect. However, these were also not protected to ensure the integrity of the containers.

We were not assured that patients, staff and the public were appropriately protected from the risk of infection and that samples would be treated in the appropriate manner. During the inspection, the practice removed the items from the front of the premises and the practice reverted to the previous system of patients handing samples into reception and collecting containers from reception. This issue was dealt with as a concern identified and escalated during our inspection and further information is at Appendix A.

There were appropriate resources to achieve good standards of cleanliness at the surgery. A cleaner cleaned the practice daily, they had a checklist to ensure they cleaned the various areas on a periodic basis. In addition to the checklists being signed off, they also had data safety sheets. The cleaning stores were locked and secured during the inspection.

The floors in the surgery were clean, as well as surfaces being clean and wipeable, with foot operated bins. Couches and chairs were in good condition, with wipeable

surfaces. Sanitisers were available throughout the surgery; patient toilet areas were clean and well stocked. PPE was available in the treatment rooms seen.

The practice had an in-date infection control policy. The policy named the IPC lead as the practice nurse as well as identifying a non-clinical IPC lead. Staff were aware of who the practice lead was and where to find the infection control policy. To ensure that the relevant staff were aware of their duties, their scope needed to be identified.

The practice is to ensure that the scope of the duties of the nominated clinical and non-clinical IPC lead are included in the policy.

During our observations of the practice, we found the following:

- That clinical curtains used to provide privacy within clinical rooms, had not been changed for some years, with some installed in 2017

- Items of Personal Protective Equipment (PPE) (disposable aprons) and cotton wool stored within clinical rooms that were unprotected from airborne contamination

- Posters and information displayed on noticeboards had not all been suitably laminated to allow for them to be cleaned in line with the most up to date IPC guidance

- We were not provided with evidence of audits of IPC and hand hygiene undertaken at the medical practice

- A lack of evidence of appropriate training for the IPC lead at the medical practice

- We were not assured that all staff at the medical practice had in place a suitable level of IPC training appropriate to their role.

This led to an immediate assurance being issued, which was dealt with under HIW's immediate assurance process and further information is given at Appendix B.

There had been an annual healthcare waste audit, to evidence actions associated with any outcomes or areas of improvement highlighted as a result of audits dated August 2023. There were appropriate waste management procedures in place. Waste was collected weekly, with bags placed in an outside store by the cleaner. All bags were clearly labelled with the point of origin. We noted that the external

store was secured with waste segregated from the sharp's bins. However, we noted that

- The external store was not labelled as a biohazard
- The practice did not have a blood borne virus policy
- The records kept of the vaccination status of staff was incomplete and one of the registrars had not completed the relevant information hepatitis B immunisations. There were also multiple staff who had not confirmed the date of booster jab, only that they had had one.

The practice is to ensure that:

- **The external waste store is labelled as a biohazard**
- **A blood borne virus policy is written and kept up to date**
- **The record of the vaccination status of staff relating to hepatitis B immunisations is up to date and contains the relevant information.**

There were appropriate hand hygiene facilities in clinical areas, including many new or refurbished areas. Any infectious patients would be seen at the end of the day to reduce the risks of healthcare associated infections.

When we spoke with the practice nurse, it was apparent that there was not a policy for needlestick injuries and there was a lack of knowledge around this area. This included not knowing how to access an appropriate setting if there was a need for post exposure prophylaxis, that is the nearest emergency department. This represented a potentially serious risk to staff health. We were told that there had been a recent example of a needle inoculation injury at a branch site, where a staff member had a needlestick injury from handling a clinical waste bag and there was no identified process for managing this. This should have provided the opportunity to develop a process and to share this with the practice. This did not happen as evidenced by relevant staff not being aware of what to do if they experienced a needle inoculation injury.

This led to a concern regarding lack of leadership. The expectation being that practice guidance would be provided by external organisations rather than actively seeking information on what the appropriate level of knowledge was and how to develop relevant understanding.

Senior staff stated that there was a policy for needlestick injuries. A few days prior there had been a needlestick injury and the practice were in the process of updating the policy by removing the reference to phoning A&E as this was no longer required. They identified that the policy needed amending including re-inserting the flow chart. As this had only just happened the practice did not have time to circulate the information. We were told that the practice senior GP was actively seeking information as discussed in depth in the visit and that the practice found that there was an issue and were in the process of addressing it.

The practice is to ensure that the needlestick procedure is updated and made known to all staff

All of the patients who answered thought the GP setting was 'very clean' (14/18) or 'clean' (4/18). All patients said there were signs at the setting explaining what to do if you are contagious (for example, COVID symptoms) and that hand sanitizers were available. All bar one patient said that healthcare staff washed their hands before and after treating them.

Only four of the patients who answered the questionnaire said they had an invasive procedure such as having bloods taken, injections and minor operations. Where they were able to recall the procedure, they all confirmed 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 practice ensured the safe prescribing of medication. The practice had clear processes in place for medicines management. There were no controlled drugs on site.

There were a number of processes for patients to request repeat medication, which were described by staff. The process within the practice to complete these medication requests was also well controlled. This included an annual text message or a letter to the patient when a review was due.

The GP provided initial training to the prescribing clerk and they also received health board training where available. The pharmacy assistant had a basic qualification and was currently following an online post-graduate course at a university and was being mentored by a senior partner.

Prescription pads were stored securely in a locked cupboard. A detailed log was kept of all manual prescription pads issued to prescribing doctors. The practice

had an audit trail of who and when prescriptions were collected, particularly if they were taken by a third party. GPs used manual prescriptions for home visits.

We spoke with nursing staff about how the cold chain was maintained for all applicable vaccines and immunisations. The practice nurse was responsible for the stock checks and the weekly ordering of vaccines. There were dedicated clinical refrigerators in place that maintained temperature within the recommendations. There were twice daily checks carried out to ensure that the temperatures remained within guidelines. Vaccines were stored correctly and according to guidelines.

There was a process in place for the weekly monitoring, checking and replacement of resuscitation equipment, consumables and associated resuscitation drugs (including oxygen).

The practice had resuscitation equipment which met the requirements for primary care equipment standards as outlined by the Resuscitation Council UK guidance. There was an out-of-date Guedel airway in one of the oxygen bags, which was removed during the inspection. This issue was dealt with under Appendix A of the report.

The practice nurse was also responsible for checking the emergency drugs and equipment on a weekly basis. The emergency drugs and equipment policy was seen and was in date. However, this policy stated that the frequency of the checks was monthly. This needed to be changed to weekly in accordance with resuscitation council guidance. Checks were also carried out by the practice nurse to ensure that all drugs and equipment were in date. However, there were no arrangements in place to ensure that drugs were stored at the required temperature, for the main drugs store and the dry stores cupboard where excess drugs are stored.

The practice is to ensure that:

- **Emergency drugs policy is updated to show that the emergency drugs and equipment is checked on a weekly basis**

- **Daily temperature checks are carried out on the rooms where the drugs are kept at room temperature, to ensure that the minimum and maximum temperatures are not exceeded.**

Staff we spoke with said that they were aware of where the emergency equipment was kept. Locum staff were informed as part of their orientation to the practice. There was an automatic external defibrillator (AED) available. Staff involved in checking the equipment were aware that there was an issue with the defibrillator

pads being out of date as they were in short supply. There was also a defibrillator in the public area next door. The practice manager had checked with the defibrillator manufacturer who assured the practice that the defibrillator would alert if the pads were not usable, when doing the weekly defibrillator check.

Safeguarding of Children and Adults
Staff knew how to recognise signs of abuse in vulnerable adults and children. There was evidence of good child protection within the practice. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies.

The training matrix provided showed that safeguarding training formed part of the practice's mandatory staff training programme. Staff had completed training at a level appropriate to their role including level three training for the safeguarding lead.

Management of Medical Devices and Equipment
The practice had processes in place to ensure all equipment was used in a safe way. An external company was responsible for checking medical devices and equipment annually. The practice had in date contracts for maintaining equipment, the equipment was sent annually to the supplying manufacturers. The relevant tests and calibration were seen and were in date. There were no issues noted with the equipment seen.

The practice used single use equipment where possible, which were disposed of appropriately.

Each GP was responsible for checking their own clinical bags for off-site patient visits. Drugs were not kept in these clinical bags; GPs would take any required medications with them for each individual visit.

Effective

Effective Care
The practice had processes in place to support safe, effective treatment and care that linked with the wider primary care services. The process by which the practice kept up to date with best practice, national and professional guidance, new technologies and innovative ways of working was described. This included care pathways, circulation of health board information and any new National Institute for Health and Care Excellence (NICE) guidance, which would be discussed as and when required. The practice used online methods of communicating guidelines and best practice to staff.

Emergency drugs were separated into three containers for different conditions. This showed that the practice had considered other life-threatening emergencies. The containers were for cardio/respiratory, diabetes and shock (meningitis, sepsis and anaphylaxis).

Patients who had contacted the practice in crisis were referred to the on-call crisis team by the GPs daily. Similarly, the nursing staff had access to a GP during the day for referring urgent concerns and patients in crisis and they would always be seen the same day. Where a patient had received crisis intervention for mental health needs, the practice would receive a discharge notification.

There were weekly 'care at home' meetings and multi-disciplinary team meetings in place to avoid inappropriate hospital admissions.

Patient records

We checked a sample of ten patient records and noted that they were clear and of a high standard, being up to date, complete, understandable and contemporaneous. However, there was poor use of clinical Read codes that made linking entries for the same problem, such as chronic problems, difficult. It was also difficult to establish why drugs were initiated and when they were stopped. Additionally, the patients' preferred language was not identified within patients' records.

The standard electronic record was used with statutory access, disposal and was secured in line with national standards. Paper records were stored in the practice branch surgeries but were not viewed as part of this inspection.

The practice needs to:

- **Introduce more clinical Read coding to describe the care and treatment given to patients, such as the signs, symptoms, treatments, investigations, occupations and diagnoses**

- **Record the patients' preferred language within the patient record.**

Quality of Management and Leadership

Leadership

Governance and leadership

There were some operational systems and processes in place to support effective governance and accountability to ensure sustainable delivery of safe and effective care. We found management were eager for the practice to succeed and offer patients a supportive service.

Staff and managers were clear about their roles, responsibilities and reporting lines, with job descriptions for staff. Information would be shared previously with staff previously by email, but now the practice used an online meeting tool as well as an online messaging tool.

The practice policies and procedures were all stored in an accessible place on the practice shared drive, to which all staff had access. The policies and procedures had been reviewed in a timely manner and were all up to date. They were well written, clear and available to all staff.

There was evidence of staff engagement programmes or access to wellbeing programmes, with the practice holding social events and gatherings for birthdays, staff leaving as well as an all-staff party for the opening of the new building. There had also been a staff mental health wellbeing awareness event.

Senior staff we spoke with said that the main challenges and pressures being faced by the practice were managing patients' expectations.

There were designated practice leads for specific practice areas, including data controller, Caldicott guardian, IPC and safeguarding leads. The senior partner was responsible for clinical oversight in the practice.

The practice was involved in cluster projects and initiatives, including some projects written by the practice manager. This included an initiative on the evaluation of care at home that each practice in the cluster participated in.

Workforce

Skilled and enabled workforce

Staff we spoke with described the induction programme in place for new staff. Staff were generally up to date with mandatory training including equality, diversity and inclusion and staff had recently undertaken cardiopulmonary

resuscitation training. We were told that non-clinical staff training needs were identified through the practice development plan or in response to an audit, significant event or complaint outcome. Training needs for clinical staff were identified during annual appraisals.

Staff described the process for employment checks (at appointment and ongoing) including relevant reference requests, professional registration details, revalidation, appraisal dates and immunisation status.

The practice manager ensured that there was always appropriate capacity and skill mix of competent staff available when required. They also had a workforce planning toolkit that kept the partners informed.

The practice was a training practice with three registrars currently. We were told that four out of the five partners had previously been in training at the practice. The practice were also encouraging training for the practice nurse in minor illness and arranging further training for the health care support worker (HCSW) who had been supported in completing a level three Diploma in Primary Care and Health Support.

Nursing staff we spoke with were clear of the responsibilities for management, administration, accountability and reporting structures within the team. The practice nurse and HCSW appeared to be clear in their scope of practice. They both agreed that there was workload allocation in accordance with their individual scope of practice. The practice nurse informed us that there was ready access to a GP for clinical guidance.

Culture

People engagement, feedback and learning
There was a duty of candour policy in place, which was clear for staff and available on the shared drive. Staff were able to describe their role under the duty. Practice staff we spoke with said that most staff had received training on the duty. We were also told that the significant events process had been amended to take into account the duty. There was an in-date whistleblowing policy noted.

Senior staff we spoke with said that staff were encouraged to raise concerns when something had gone wrong. The practice described one instance where the duty had been exercised.

The practice manager told us how they recorded all concerns and complaints, as well as how they were addressed. There was also an up to date policy on how there should be managed that included the process, timescales and sources of

support and advocacy. All staff knew where to find the procedure at the practice. The procedure aligned with and referenced Putting Things Right (PTR). However, whilst a copy of PTR was attached to the letter sent to patients who made a formal complaint, the poster itself was not clearly displayed at the practice. Based on the replies to the questionnaire, 61% of patients knew how to complain about poor service if they wanted to.

The practice must clearly display the concerns process - Putting Things Rights (PTR) in the patient waiting areas.

The practice manager was responsible for handling concerns and complaints. A document called 'Review of Practice Complaints 2023' was noted during the inspection. Staff we spoke with said they felt enabled to raise concerns and we were told that the practice had changed its ways of working, based on a complaint relating to responding to prescription queries.

We were told that the practice had discussed the results of the feedback in August 2023, which combined details of eConsult, emails, an annual patient survey letter and suggestion box and compared the results to a local practice of similar size for context. There was positive evidence of listening to feedback from patients and making changes as a result. We were told that the practice did share the results of the patient survey with the patients. The actions taken because of the feedback need to be clearly displayed on a board similar to a "you said, we did" board.

The practice needs to ensure that the results of patient feedback are clearly made known to patients in the main reception on a board similar to a 'You said, we did' board.

There was a feedback policy in place, which was in date. The results of the most recent NHS GP survey showed that there had been over 300 respondents from patients in the practice with 90% positive feedback. In all, 99% of patients said they received assistance when needed, 87% felt the waiting time was ok, 91% felt listened to, 94% felt things were explained well. The themes identified were more face-to-face appointments needed, making eConsult more user friendly and that the hormone replacement therapy (HRT) website page was difficult to access. However, only seven patients confirmed in the HIW questionnaire that they had been asked by their GP practice about their experience of the service provided.

Over half of the patients who answered were able to get a same-day appointment when they needed to see a GP urgently and said they could arrange routine appointments when needed. Only half of the patients who answered were offered the option to choose the type of appointment they preferred. Almost all patients

said they were content with the type of appointment offered. Some comments we received about accessing the GP are below:

> ***"I was ill in bed with a chest infection and low oxygen and was told I couldn't get any antibiotics unless I came to the surgery to be seen. Difficult when feeling very unwell. Availability of house calls unknown."***
>
> ***"Significant medical conditions. Need to see a doctor not nurse or other practitioner. My health online system is onerous and dreadful to navigate. Diabetic, heart condition, low oxygen and still not able to get urgent appointment for antibiotics for chest infection."***
>
> ***"Doctor says make appointment, receptionist says no."***
>
> ***"The appointment booking system is diabolical. Waiting room empty, can't get to see a Dr."***

We were told that both the practice manager and reception manager were visible and approachable and that staff at all levels were encouraged to speak up when they had new ideas or concerns. There were regular staff meetings, daily meetings amongst the GPs, nurse practitioner and practice manager. Senior staff we spoke with also described how a recent potential drop in morale was addressed quickly to enable staff retention and as a consequence staff morale improved. This included re-evaluating staff roles and responsibilities.

Information

Information governance and digital technology

The practice demonstrated that they were able to manage data in a safe and secure way. There were systems in place, including information and communications technology, to ensure the effective collection, sharing and reporting of data.

There was information displayed on the website about the privacy policy and there was also information on display in the practice. There was also a poster to explain the same to children on how data was handled. The practice annually completed the Welsh Information Governance Toolkit, a self-assessment tool enabling organisations to measure their level of compliance against national Information Governance standards and legislation.

Learning, improvement and research

Quality improvement activities

It was clear that concerns and complaints were used as an opportunity to learn and drive continuous improvement. The practice engaged in activities to continuously improve by developing and implementing innovative ways of delivering care.

Whole system approach

Partnership working and development

Staff we spoke with told us about the cluster initiatives, which were based upon the needs of the whole cluster rather than just a single practice. There were regular cluster meetings when required, regular child protection meetings with the health visitor, multi-disciplinary team meetings and virtual ward meetings.

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
The practice had placed a white, plastic bin outside of the building for the collection of patient clinical samples. This was not appropriately labelled in line with IPC guidelines of its contents and did not contain the appropriate clinical waste bag should the contents of the bin require disposal. Furthermore, no measures were in place to prevent cross contamination of clinical samples, preserve their integrity or to prevent damage to them by the environment including sunlight, heat, rain, or insects. Adjacent to the sample bin, was a set of plastic drawers that contained empty clinical sample collection pots and swabs including charcoal swabs, urine analysis pots, faecal sample collection pots and universal sample containers for patients to collect. However, these were also not protected from heat, sunlight, rain or insects and no controls were in place to ensure the integrity of the containers.	No measures were in place to prevent passers-by from accessing either the sample collection bin or container drawers or to warn of the hazardous material inside. We were not assured that patients, staff, and the public were appropriately protected from the risk of infection and that samples would be treated in the appropriate manner.	We informed the practice of our concerns.	The practice has reverted to the previous system of patients handing samples into reception and collecting containers from reception.

There was an out-of-date Guedel airway in one of the oxygen bags.	The practice resuscitation equipment was incomplete and not all items were in date.	We informed the practice of our concerns.	This was removed during the inspection.

Appendix B – Immediate improvement plan

Service: Llantwit Major & Coastal Vale Medical Practice - Eryl Surgery

Date of inspection: 5 September 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 our observations of the practice, we found that clinical curtains used to provide privacy within clinical rooms, had not been changed for some years, with some installed in 2017. We also found items of Personal Protective Equipment (PPE) (disposable aprons) and cotton wool stored within clinical rooms that were unprotected from airborne contamination. Posters and information displayed on noticeboards had not all been suitably laminated	The practice is required to: • Provide the lead IPC nurse with an appropriate training programme to support them in their role • Undertaken an annual IPC audit of the medical practice	We have contacted C&V LHB Lead Nurse and asked for details of this training programme. The Senior Nurse for Primary Care Development has advised that Level 2 is sufficient for General Practice, and that Level 3 is not available for General Practice Nurses. Our lead IPC Nurse has Level 2. The C&V Nursing team have recommended an IPC Audit with actions identified for going	LW LW	3 months Immediate

to allow for them to be cleaned in line with the most up to date IPC guidance. Furthermore, we were not provided with evidence of audits of IPC and hand hygiene undertaken at the medical practice or evidence of appropriate training for the IPC lead at the medical practice. We were not assured that all staff at the medical practice had in place a suitable level of IPC training appropriate to their role.		forward. The IPC Audit will be undertaken on an annual basis.		
	• Undertake regular hand hygiene audits of staff.	Our ANTT facilitator provided evidence of the hand hygiene audits she has undertaken in the practice. We will continue to undertake hand hygiene audits and have asked for further clarification from Cardiff & Vale LHB on the format and frequency required in additional to ANTT for these additional audits.	LW	Immediate
	• Replace all expired curtains within clinical rooms	All expired curtains have been replaced with new curtains.	LW	Immediate
	• Ensure PPE and items used in the treatment of patients is stored in an appropriate manner to prevent against contamination and uphold standards of IPC in line with IPC guidelines	PPE items to be kept in containers until required for use. Cotton wool to remain in packaging until required Message circulated to all staff on importance of storage of PPE in rooms to prevent	LW	Immediate

		contamination and uphold standards of IPC		
	• Remove all paper posters and notices and replace with laminated versions where possible	The minority of notices and posters that were not laminated have now been laminated or removed.	LS	Immediate
	• Ensure all staff have in place a level of training in IPC appropriate to their role.	All clinicians that did not have Level 2 in IPC at the time of the inspection have achieved that since the inspection, with the exception of clinicians on annual leave. Non-clinical staff have Level 1 IPC	RK	2 weeks to allow for staff on A/L

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): **Emma Procter**

Job role: **Business Partner**

Date: **14 September 2023**

Appendix C - Improvement plan

Service: Llantwit Major & Coastal Vale Medical Practice - Eryl Surgery

Date of inspection: 5 September 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
There was a room next to reception that could be used to discuss any issues with patients. However, during our inspection we noted that the room also contained patient information including patient letters. This room should not be used if there is any information on display nor if the patient is left unattended in the room. Senior staff stated that it was their process to remove the portable in-trays to create a confidential space and that personal	The practice is to continue ensure that the room used to speak to patients in private is cleared of any personal information and that any information kept in the room is kept secured.	As informed during the visit, if a room in reception is required to have a private discussion with a patient, we remove the portable in-trays with patient information and ensure there is no patient information on display.	Lucy Staniland	Actioned: In place during inspection.

information would not be on display.				
Written information displayed in the practice was generally available in English only. We were told there were no Welsh speaking staff working at the practice currently. Where required, we were told staff could access a translation service to help them communicate with patients whose first language was not English.	The practice must put arrangements in place to provide an effective 'Active Offer' to patients and expand the selection of information available, taking into consideration the communication needs and wishes of patients using the service.	During the HIW visit we added a power point slide to the large display screen in reception inviting patients to access information in Welsh. As we receive leaflets in Welsh, we will put them up in the leaflet rack in the waiting area.	Emma Procter	Actioned: In place during inspection. Actioned: On-going
In the questionnaire, three respondents felt that they had faced discrimination when accessing or using this health service.	The practice is to provide HIW with information about the efforts it has made and will continue to make to ensure patients are not discriminated against.	We do not discriminate. We require specific information to address this action to ensure that communication is clear in this area. Equality & Diversity Policy circulated to staff.	Emma Procter	Actioned Actioned

		All Staff have completed elearning Wales “Treat Me Fairly” Training to be given at April CPET		Actioned 30 April 2024
Staff only areas were clearly marked although the signage for navigation around the practice were not clear especially considering the elderly patient demographic.	The practice should ensure that the signage for navigation around the practice is clear, taking account of the patient demographics.	We are liaising with a company regarding ordering new signage.	Emma Procter	Actioned: 3 months
The policy named the IPC lead as the practice nurse as well as identifying a non-clinical IPC lead. To ensure that the relevant staff were aware of their duties, their scope needed to be identified.	The practice is to ensure that the scope of the duties of the nominated clinical and non-clinical IPC lead are included in the policy.	The policy has been revised to ensure that the scope of mentioned personnel is clearly identified.	Louise Williams	Actioned
We noted that	The practice is to ensure that:			

• The external store was not labelled as a biohazard.	• The external waste store is labelled as a biohazard	A biohazard label has been fixed to the external store.	Louise Williams	Actioned
• The records kept of the vaccination status of staff was incomplete and one of the registrars had not completed the relevant information hepatitis B immunisations. There were also multiple staff who had not confirmed the date of booster jab, only that they had had one.	• The record of the vaccination status of staff relating to hepatitis B immunisations is up to date and contains the relevant information	HEIW undertakes thorough checks to ensure that the vaccination status of registrars is complete prior to allocating them to practices. We have asked staff to find the information regarding the date of their booster jabs.		Actioned Actioned: On-going
• The practice did not have a blood borne virus policy.	• A blood borne virus policy is written and kept up to date.	We have liaised with C&V LHB for details regarding a blood borne virus policy. They have shared some secondary care policies which we have adapted as they do not have one for primary care.		Actioned

When we spoke with the practice nurse, it was apparent that there was not a policy for needlestick injuries and there was a lack of knowledge around this area. This included not knowing how to access an appropriate setting if there was a need for post exposure prophylaxis, that is the nearest emergency department. This represented a potentially serious risk to staff health. Senior staff stated that there was a policy which was in the process of being updated.	The practice is to ensure that: • A needlestick procedure is written and made known to all staff • All staff are made aware of any events that would require relevant learning in a timely manner together with the relevant actions to be taken • Communication is improved between groups of staff to ensure that all are aware of significant incidents and practice changes.	There was a needlestick procedure, this was shared at the end of the visit. It had been updated that week as we had discovered that A&E was the only option for primary care staff. Significant events are documented and discussed in teams meetings. A summary is then presented for further review at the following CPET meeting. This was shared during the visit	Louise Williams	Actioned Actioned
The emergency drugs and equipment policy was seen and was in date. However, this policy stated that the frequency of the checks was	The practice is to ensure that the: • Emergency drugs policy is updated to show that the emergency drugs and	The emergency drugs policy has been updated and emergency drugs are checked daily.	Louise Williams	Actioned

monthly. This needs to be changed to weekly in accordance with resuscitation council guidance. Checks were also carried out by the practice nurse to ensure that all drugs and equipment were in date. However, there were no arrangements in place to ensure that drugs are stored at the required temperature, for the main drugs store and the dry stores cupboard where excess drugs are stored.	equipment is checked on a weekly basis • Daily temperature checks are carried out on the rooms where the drugs are kept at room temperature, to ensure that the minimum and maximum temperatures are not exceeded.	Daily temperature checks are undertaken.		Actioned
We checked a sample of ten patient records, there was poor use of clinical Read codes that made linking entries for the same problem, such as chronic problems, difficult. It was also difficult to establish why drugs were initiated and when they were stopped. It was also noted that the patients' preferred	The practice needs to: • Introduce more clinical Read coding to describe the care and treatment given to patients, such as the signs, symptoms, treatments, investigations, occupations and diagnoses.	This has been highlighted to the clinicians. The practice is changing the clinical software system and moving from vision to EMIS. We understand that a benefit of this move is that EMIS prompts recording and collection of these codes.	Dr Rosemary Kavanagh	Actioned

language was not identified within patients' records.	• Record the patients' preferred language within the patient record.	This has been highlighted to the clinicians and they are recording patients preferred language into the patient record.		Actioned
The complaints procedure aligned with and referenced Putting Things Right (PTR). However, whilst a copy of PTR was attached to the letter sent to patients who made a formal complaint, the poster itself was not clearly displayed at the practice.	The practice must clearly display the concerns process - Putting Things Rights (PTR) in the patient waiting areas.	There was information on PTR on the waiting room noticeboard. This information is now displayed on the notice board in the main waiting room area	Emma Procter	Actioned
There was positive evidence of listening to feedback from patients and making changes as a result. However, there was no evidence clearly on display for patients to show how the practice had learned and improved based on feedback received.	The practice needs to ensure that the results of patient feedback are clearly made known to patients in the main reception on a board similar to a 'You said, we did' board.	There was feedback from the results of the Patient Survey from 2023 on a notice board. Patient Survey feedback from 2024 will be displayed in the format requested with the actions to indicate "you said, we did", on the notice board	Emma Procter	Actioned: In place during inspection 1 month

		in the main waiting room area, along with the results from this Patient Survey.		

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): Emma Procter

Job role: Business Partner

Date: 22 February 2024