Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report
(Announced)
Brecon Medical Practice, Powys Teaching 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 Brecon Medical Practice, Powys Teaching Health Board on 17 September 2024.

Our team for the inspection comprised of two HIW healthcare inspectors and three clinical peer reviewers. The inspection was led by a HIW senior healthcare inspector.

During the inspection we invited patients or their relatives / carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of eight questionnaires were completed by patients or their carers and one was completed by staff. 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.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
There was good access into the premises allowing patients with impaired mobility and wheelchair users to easily access the facilities. The patient waiting room was clean and spacious, with a separate room available for private discussions.

Responses were mainly positive in the patient questionnaires, and most rated the service as ‘very good’ or ‘good’. Patients who used the service were able to access information to help promote their health and wellbeing and lead a healthy lifestyle. A variety of patient information was also available on the on the practice website.
The environment maintained the privacy and dignity of patients, and people were treated with respect. Some telephone conversation could be overheard in reception, although staff did not discuss patient identifiable details. In addition, very few patients responding to our survey felt they could talk to reception staff without being overheard.
There were processes in place to ensure patients could access care via the appropriate channel in a timely manner, and with the most appropriate person. A ‘patient safety at a glance’ board was also in place within the administrative area, which contained details of patients receiving care in the community, namely ‘the virtual ward’.

The practice provided information to patients and communicated in a way that was clear, accessible and in a language and manner appropriate to their individual needs. They also communicated in a way to enable them to make informed decisions about their care.

The practice's culture and processes supported the equality and diversity of individuals. Equality and diversity were promoted through the practice policies and staff training.

This is what we recommend the service can improve:

- Ensure patients speaking at reception could do so in a way that upheld their privacy and confidentiality
- Inform patients of the availability of chaperones in all treatment and consultation rooms.

This is what the service did well:

- Ensured that patients felt they were treated with dignity and respect with good service
- Upheld the rights of all patients
- Good health information available
- Waiting areas clean, bright and spacious.

Delivery of Safe and Effective Care

Overall summary:
The processes in place at the practice protected the health, safety and wellbeing of all service users. All areas within the practice were clean, tidy, free of clutter and in a good state of repair.

The practice environment, policies and procedures, staff training, and governance arrangements uphold the required standards of IPC, and maintained the safety of staff and patients. Appropriate handwashing facilities were available and handwashing technique notices were present within in each clinical room.

We considered how the practice assures itself regarding staff immunity to hepatitis B, but there was no evidence recorded to demonstrate their immunity to protect themselves and patients. This was therefore managed under our immediate assurance process. Action has since been taken to resolve this issue.

Disposable privacy curtains were in place in consultation rooms, and in one, these were dated as in place in 2023. However, disposable privacy curtains in patient treatment areas should be changed and dated on a six-monthly basis or sooner if soiled. In our patient questionnaires, all but one said that hand sanitisers were available, and that clinical staff washed their hands before and after treating them.

There were portable oxygen cylinders available and ready to use at the practice and were appropriately stored within cannister holders. We were told that all clinical staff were aware of how to operate the cylinders, however, some staff were yet to complete the British Oxygen Company (BOC) online training.

There was appropriate resuscitation equipment and emergency drugs in place to manage a patient emergency, such as a cardiac arrest. These met the primary care equipment standards as outlined by the Resuscitation Council UK guidance. Staff had completed appropriate training for medical emergencies and all clinical staff had undertaken appropriate basic life support training.

There were processes in place to support safe and effective care and the practice had links with the wider primary care services. The practice also ensured that

patients requiring mental health support were appropriately signposted and supported. The practice policies, procedures and culture ensured that people and staff were able to report and manage safeguarding concerns.

Patient records were clear, written to a good standard and complete with appropriate information. They were contemporaneous and were easy to understand by other clinicians reviewing the records. These were stored securely and were password protected from unauthorised access.

This is what we recommend the service can improve:

- Replacing disposable privacy curtains when they are due to be changed or when they pose an infection prevention control risk
- Ensure that the work of non-medical prescribers is reviewed on a regular basis.

This is what the service did well:

- Good compliance with emergency equipment
- Good quality patient medical notes
- Regular weekly clinical meetings which were well recorded.

Quality of Management and Leadership

Overall summary:
There were processes in place to support good governance, leadership and accountability, to ensure sustainable delivery of safe and effective care. Staff and managers were clear about their roles, responsibilities, reporting lines and the importance of working within their scope of practice.

Regular meetings were held with team leaders, and minutes and actions were completed and disseminated to their teams. In addition, any changes to policies or procedures following their review were also discussed with and sent via email.

The practice had enough staff with the right knowledge and skills available at the right time to meet demand. Staff are supported to complete training relevant to their role, and records were kept of mandatory and other training.

Staff demonstrated how they act and learn from any patient feedback, through the process in place which captures the information on specific forms. Lessons learned and action plans are implemented, and the details are shared with all staff. However, in our patient's survey responses, none said that they had been asked by the practice about their experience of the service provided, and few knew how to complain about the service.

Staff understood their responsibilities under the duty of candour and had received duty of candour training. However, the practice did not have a duty of candour policy in place but used its local health board duty of candour guidance.

The practice understood its responsibilities when processing information and demonstrated that personal data was managed in a safe and secure way, and an information governance policy was in place and was current.

Immediate assurances:

- The inspection team were not provided with evidence that the practice could assure itself regarding the hepatitis B immunity status of clinical staff, to protect themselves, those they are close to and work with, and people attending the practice for clinical consultations or care.

This is what we recommend the service can improve:

- Monitor and complete annual staff appraisals
- Ensure policies and procedures are version controlled, list an author, an implementation date and review dates.

This is what the service did well:

- Good collaboration between the practice and the local GP cluster
- Mandatory staff training compliance
- Well managed complaints process.

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

HIW issued a questionnaire to obtain patient views on the care at Brecon Medical Practice for the inspection that took place in September 2024. In total, we received eight responses from patients at this setting. Responses were mainly positive, six of the eight respondents who answered rated the service as 'very good' or 'good'. Some of the comments we received about the service and how it could improve included the following:

> ***"Waiting times for phones to be answered. Have to wait for GP to ring you and they decide if you are to be seen that day. Go back to the old systems when we had family doctors because that way you don't have to explain to the different GP's what has been happening to you. "***
>
> ***"It's a shame the system in the morning is so frustrating. I'm pleased we now know when we phone the surgery our place in the queue, however, this is a prime time to have more staff on the phone lines. Average waiting time 45 mins!"***
>
> ***"The service I receive for my medical needs is fine. However, I am involved with taking an elderly parent to the surgery and with their increasing medical needs I'm worried about their continuity of care. We never seem to speak or even see the same doctor to discuss the ongoing and growing medical needs."***
>
> ***"It takes a long time to wait on the phone to get to talk to a receptionist. The lines are only open from 8 - 11 am for appointments to see a GP. Cannot understand why you can't make an appointment during the afternoon and see a GP on an allotted appointment. Rather than first come first serviced, I am old and lived in Brecon all my life and the service provided is not good enough."***
>
> ***"I felt rushed when explaining my needs and couldn't take time - especially phone appointments.***
>
> ***"The initial system via phone is at breaking point. At least 30 minutes to speak to reception. If a GP call back is agreed it can take most of the***

day and you simply have to be available for however long it takes. Sometimes reception will give a broad time scale eg phone back is after 11. It has resulted in my not contacting the GP when I need too."

"I received good service in checking for cancer etc. once it was routine condition the GP service was patchy and less interested."

Person-centred

Health promotion

Patients who used the service were able to access information to help promote their health and wellbeing and lead a healthy lifestyle.

There were several examples of healthy lifestyle being promoted at the practice, which included smoking cessation and eating well. There was also an information screen at the practice which promoted different campaigns, such as the flu campaign and various NHS campaigns. There was also a variety of information on the practice website, including asthma advice, domestic abuse and mental health support. This was in addition to a section on self-help.

There was patient accessible health monitoring equipment available at the practice, for blood pressure (BP), height and weight. These were in the waiting area, and once completed, patients provided a printout of their results to reception staff for filing in their records. If the BP reading was outside the acceptable range, then the reception staff informed the relevant GP.

We found some initiatives had been introduced at the practice, such as the availability of musculoskeletal physiotherapists and a health visiting team who worked out of the practice. There were also practice baby clinic days where health visitors were invited to attend as well as district nurses. Macmillan nurses were also hosted at palliative meetings every month. The practice also saw learning disability (LD) patients at LD clinics by a physician's associate.

Staff told us they had already started the children's flu vaccination programme for those aged two to three years. Staff said they would be offering the winter flu vaccination programme from the end of September 2024 and that several flu clinics had been arranged for eight weeks of the flu season. This would be promoted on social media, the practice website and by text messaging. For patients without digital access, the campaign would be promoted at the practice, staff would also telephone eligible patients and there would be a news article in the local newspapers.

All respondents to our patient questionnaire felt there was health promotion and patient information material on display, but only 43% said they were offered healthy lifestyle advice.

In our questionnaire responses, only one person said they cared for someone with disabilities, long-term care needs or terminal illness. We noted several posters displayed in the waiting room providing information to carers on the support available to them. There was also a section on the website where patients could register details of their carer.

Dignified and respectful care

The environment supported the rights of patients to be treated with dignity and respect. The clinical rooms provided appropriate levels of privacy, with lockable doors. There were also disposable privacy curtains within the examination rooms. A room was also available to maintain discreet conversations between patients and staff next to the reception area. Whilst some telephone conversation could be overheard in reception, we were told that no patient identifiable information would be discussed. However, only 17% of patients said that they could talk to reception staff without being overheard.

The practice must ensure that all patients conversations, including telephone conversations, are private to ensure the privacy of all patient issues.

The practice offered both male and female chaperones in all appropriate circumstances and there was a chaperone policy in place. However, whilst there was a sign in reception saying that chaperones were available on request, there was not a notice in each clinical room. A GP at the practice provided staff with the chaperone training. All but one patient said they were offered a chaperone for intimate examinations or procedures.

The practice must ensure that there is a chaperone availability notice displayed in each consultation and treatment room to advise patients of the service.

All respondents in our patient questionnaire felt they were treated with dignity and respect, that measures were taken to protect their privacy and that the GP explained things well and answered their questions. All but one felt involved in decisions about their healthcare.

Timely

Timely care

There were processes in place to ensure patients could access care via the appropriate channel in a timely manner, and with the most appropriate person.

Arrangements for patients to access services were described, with different access models being used. The practice access policy was available on the practice website. Most appointments were made by telephone. Staff working on reception had a list of medical conditions where they would signpost patient to other appropriate service providers, for example, an optician for eye problems and a dentist for dental problems.

A triage process known as 'Prioritisation of patients: A guide to urgency for non-clinical staff' (POPGUNS) was used to identify urgent cases that needed an ambulance. Less urgent patients were booked with a GP for an initial telephone assessment and were subsequently managed either by phone or through a face to face appointment. Sick children and vulnerable patients were always seen face to face.

The practice had a 'patient safety at a glance' board in the administrative area. This contained details of patients receiving care in the community, namely 'the virtual ward' were kept. Each day there was a Community Resource Team (CRT) doctor who discussed the patients on the virtual ward with the district nurses, who then made contact and reviewed these patients as appropriate, including home visits. The CRT doctor was also responsible for dealing with any urgent patient issues at the local community hospital and minor injuries unit (MIU). In addition, they completed the medical home visits for the practice, which averaged approximately eight visits per day.

Senior staff told us that the telephone patient triage assessment conducted by a by GP was introduced before COVID-19 and was liked by both patients and the practice staff. This resulted in patients being seen by the appropriate practitioner in the appropriate setting and timeframe. This positive feedback was also provided by the patient participation group.

Where a patient required urgent mental health support, or they were in crisis and needed urgent mental health assessment, they would be assessed by the duty doctor who could call NHS 111 Wales, option 2 (mental health support line), as required. This was an option that could also be used by a patient themself, if they needed urgent mental health support or by a person needing advice for someone else. Children with mental health issues would have an urgent Child and Adolescent Mental Health Services (CAMHS) referral and could also contact NHS 111 Wales, Option 2.

All but one respondent to our patient questionnaire felt they could obtain a same-day appointment when they needed to see a GP urgently, but less than half felt they could arrange a future routine appointment when necessary. In addition, all

but one patient said they were not offered the option to choose their preferred appointment type and less than half felt content with the type of appointment they were offered. Some patient comments include the following:

> ***"You cannot ask for a face-to-face appointment. You are directed to go through the 8am phone triage system. I find phone appointments very awkward and not as thorough / cues etc. I don't use computers. I don't have a smart phone."***
>
> ***"GPs make decisions to see you or not over the phone. They cannot see how ill you look. This service is not good enough. Also, you sometimes have to travel to Sennybridge to see a GP and have to rely on other people to transport you there."***
>
> ***"Phone system - very long waits - 30 minutes most often, rarely same day, face to face all phone. It is difficult to find information. In person only for bloods, an intimate examination, primarily phone. I had several phone appts over about 6 weeks all different GPs and little continuity since my medical need was routine it felt very low priority."***

Equitable

Communication and language

The practice provided information to patients and communicated in a way that was clear, accessible and in a language and manner appropriate to their individual needs. They also communicated in a way to enable them to make informed decisions about their care.

Patients with visual or hearing problems were flagged on the patient records and were given the most appropriate appointment to meet their needs. The practice made use of translation services, such as an online translation application and British Sign Language services where appropriate.

There were good processes for the flow of patient letters and patient documents circulated around the practice. Information from secondary care was recorded and acted upon appropriately, such as inpatient hospital discharge letters, outpatient letters and patient results. There was a clear workflow to clinicians of incoming correspondence. This was supported by a current workflow policy. Hospital letters and discharge summaries were received by administration staff who had received training by one of the GP partners in processing documents, including some relevant Read coding. We reviewed an audit trail of a sample of discharge letters, outpatient letters and blood results and these were in order.

For any child who did not attend an appointment at the practice or for a hospital appointment, details were provided to the GP and were followed up appropriately. In addition, attendances of children at an emergency department or minor injuries unit (MIU) were also followed up by the GP practice.

Messages were communicated internally by staff using tasks in EMIS, the electronic patient medical records system. The practice ensured communications were read and acted upon, as EMIS recorded any outstanding actions and these were monitored by the practice manager. Most information was received by the practice electronically and any paper documents received would be scanned into EMIS by the administration team.

The records of patients seen by the out of hours GP service would be sent electronically directly to the patient record and alerted the GPs to action as appropriate. The practice ensured that people who required further investigations or tests were appropriately followed-up and were signposted to the appropriate team.

If there were medicine reconciliations required, the documents would be passed to the Red Kite pharmacy team who actioned this, which reportedly worked well. The pharmacy team also dealt with all Shared Care agreement requests for medications, such as Methotrexate, to treat rheumatoid arthritis and psoriasis and for oral anticoagulants, which helped prevent blood clots and strokes. Monthly reviews were also undertaken for patients on disease-modifying antirheumatic drugs (DMARDs), used to slow down disease progression of rheumatoid arthritis. The protocol used for monitoring these patients was developed by one of the GP partners and had been shared with other practices within the cluster.

There was a hearing loop available in the main reception, whilst there was no information in braille, we were told that the patient participation group had a visually impaired member, who had not raised this as an issue.

Staff told us that if there were any delays with appointment times, they would inform the patients waiting in reception. When considering their experience of appointments, 75% of respondents to our patient survey said their appointment was on time.

We were told that there were no Welsh speaking members of staff at the practice, and staff were not aware of the ‘active offer’, which meant providing a service in Welsh without someone having to ask for it. Additionally, most information on display was only available in English. The electronic patient check-in system was available in English and Welsh. In addition, the system was available in Nepalese, due to the significant number of Nepalese patients registered at the practice.

The practice must ensure that

- **All staff are made aware of the 'Active Offer' in Wales, to provide services in the medium of Welsh and to facilitate this using translation services where appropriate, in the absence of Welsh speaking staff**

- **More bilingual information is available for patients using the practice.**

Regarding access to the practice, most patients said they were satisfied with the opening hours, with few saying they could not contact the practice when needed. For patients with an ongoing medical condition, again, few said it was not easy to access the regular support they needed. Most patients said they knew how to access out of hours GP services, if they could not wait until the practice was open.

All patients said their identity was checked, such as date of birth and address during appointments. Only 57% said their allergy status and ongoing medical conditions were checked prior to the GP prescribing new medications, 63% felt they had enough time to explain their health needs and 88% felt they were listened to.

The practice must reflect on the patient feedback in this report and consider what improvements can be made to address the less than positive feedback, such as access to appointments, contacting the practice for support when needed and for ongoing medical conditions.

The practice must ensure that clinical staff check a patient's allergy status prior to prescribing new medication.

Rights and equality

The practice's culture and its processes in place supported the equality and diversity of individuals. Equality and diversity were promoted through the practice policies and staff training.

Access to the premises was appropriate for those with mobility issues or wheelchair users and all patient treatment and consultation rooms were located on the ground floor. There was a stair lift to the first floor for staff to use as necessary. All patients said that the building was easily accessible and all but one felt the practice was 'child-friendly'.

Staff told us that one member of the reception team was very active in the dementia community and was designated the practice dementia champion. Another member of staff was also active within the Nepalese community.

Senior staff said that the practice had hosted several lunchtime sessions with MIND, a mental health charity, and were in discussion to allow the charity to use one of their consultation rooms to support the mental health needs of patients where appropriate.

Where applicable, staff were supported with reasonable workplace adjustments which included standing desks in some clinical rooms and flexible working with an individual working from home. Additionally, some members of staff worked condensed hours over four days a week.

Staff said they were aware of the patients with additional needs, such as neurodiverse patients, with alerts on the patient records. The practice was also proactive in upholding the rights of transgender or non-binary patients and used their preferred names and pronouns as appropriate.

Most respondents to our patient questionnaire felt they could not always access additional healthcare services in their preferred place or at the right time. The comments we received include the following:

> ***"No, because I live in Powys, we have not got services or access that other counties have in Wales. Also, we have to travel over a half hour or hour for our appointments and treatment. Powys covers a third of Wales and we are treated like second class citizens."***
>
> ***"Ongoing management of routine conditions is poor. I only contact GP if local pharmacy says so."***

Delivery of Safe and Effective Care

Safe

Risk management
The processes in place at the practice protected the health, safety and wellbeing of all service users.

All areas within the practice were clean, tidy, free of clutter and in a good state of repair. Clinical rooms were well stocked with items and equipment. Staff seemed very happy in the workplace, with a positive attitude. The lead nurse was innovative, seemed to enjoy her role, and spoke highly of how supportive, encouraging and approachable the management and senior clinical team were.

We were told that the health and safety management company used, to conduct audits, visited the practice annually and produced a report following their audit. Risk assessments were undertaken for any patient home visits and a lone working policy was in place. The practice communicated any key health and safety information to staff, including those undertaking visits to residential or nursing homes.

The practice had an appropriate business continuity and emergency preparedness plan in place, which was available on the shared drive. This had been updated to include pandemic modifications. The GP partners were long serving staff who provided stability at the practice. The practice was also a GP training practice and number of trainees were now established GPs at the practice.

The management team and structures were good and the way that the teams worked and supported each other was good for Business Continuity. There was a clear process in place for managing patient safety alerts. These were sent to relevant staff by email and were also available on the shared drive. The practice reviewed and discussed significant events (including patient safety incidents) on a chat based online workspace with the relevant staff.

There were standardised nursing staff meeting notes, which allowed for continuity of meetings with actions and learning points, these were formal and in-depth. This was a good way of learning and making improvements in the practice.

Infection, prevention and control (IPC) and decontamination
The practice environment, policies and procedures, staff training and governance arrangements uphold the required standards of IPC and maintained the safety of

staff and patients. The practice also had suitable facilities to allow for segregation of people where appropriate, to reduce the risk of healthcare acquired infections.

However, when we considered how the practice assured itself about staff immunity to hepatitis B, there was no evidence recorded to demonstrate their immunity status to protect themselves and patients. We discussed this with senior staff and were told that evidence was sought by the IPC lead (GP partner), before staff started working at the practice. Without evidence to demonstrate this during the inspection, we were not assured the practice could assure itself regarding the hepatitis B immunity status of all clinical staff. This was therefore dealt with under our immediate assurance process, highlighted in Appendix B.

There were two nurses appointed as IPC leads. The lead nurse told us there was a staff development policy in place, and this included undertaking IPC training external to the practice. All IPC training was undertaken as part of the annual training programme.

The IPC audits undertaken were described to us and included any ongoing actions for improvement. There was a current IPC policy in place and a process was in place to ensure staff remained up to date with the most recent guidelines for IPC.

Within the foyer, universal containers appropriately enclosed in bags, were available to patients in a ‘sample bottle tree'. Where necessary, patients could collect a sample bottle from the foyer, which reduced footfall into the surgery and facilitated ease of collection for patients, rather than them needing to wait for reception staff to provide them with a bottle.

The practice had appropriate procedures for waste management, which included the safe disposal, transport and collection of healthcare waste. All areas were clear of clutter and there were appropriate female hygiene bins in place.

Appropriate handwashing facilities were available and handwashing technique notices were present within in each clinical room. There was a policy in place for needlestick or sharps injuries and this was highlighted in the staff induction programme.

There were disposable privacy curtains in place in one consultation room, one of which was dated as in place in 2023. The disposable privacy curtains in patient treatment areas should be changed and dated on a six-monthly basis or sooner if soiled.

The practice must ensure that all the disposable privacy curtains used in treatment and consultation rooms are replaced every six months or sooner if soiled.

In our questionnaire, most patients felt the setting was 'very clean' or 'clean', and all but one respondent said there were notices in place, explaining the procedure if patients attending with a contagious infection. In addition, all but one patient said that hand sanitisers were available and the majority said that clinical staff washed their hands before and after treating them.

Four respondents in our patient survey said they had received an invasive procedure, such as a blood test, injection or minor procedure. All patients said that the equipment used was individually packaged or sanitised and that antibacterial wipes were used to clean their skin before the procedure. Additionally, all but one patient said that staff wore gloves during the procedure.

Medicines management

We found the medicines management process was generally good. The practice was a dispensing practice; however, we did not review the dispensing of medicines during the inspection.

The practice had two non-medical prescribers; a pharmacist and an advance nurse practitioner, who had recently completed their training as a prescriber. However, there was no formal processes in place to review and oversee the competency of non-medical prescribers. Therefore, following discussion with staff, they said they would implement a process and undertake regular audit of their prescribing and consultations.

The practice must ensure that a formal process is implemented to review and oversee the competency of non-medical prescribers.

There was a cold chain policy in place and all nurses were aware of the policy. This was also highlighted in the staff induction process and mandated training. There were five medicine refrigerators in the nurse treatment room, temperature checks were checked and recorded on a daily basis and the fridge temperature records were downloaded monthly. Vaccines and medications were appropriately stored within their designated fridge.

Controlled drugs (CDs) were checked on monthly basis for expiry dates, and two registered clinical staff checked out any CDs. The keys to the CD drug cupboard were kept securely in a separate place and were accessed by nursing staff only. The CD register was also secured in a locked cupboard.

The drugs we checked during the inspection were all in date. Some were due to expire in October and November 2024, staff were aware and the lead nurse had ordered the replacement drugs. Expired drugs, syringes and needles were disposed of safely through the medicines management team in the local health board.

Staff were aware of how to report any adverse drug reactions through the yellow card scheme.

There were portable oxygen cylinders available and ready to use at the practice. They were appropriately stored within cannister holders. The practice had received the Welsh Health Circular WHC/2024/036 Oxygen cylinders: regulation 28 report and patient safety notice 041. We were told that all clinical staff were aware of how to operate the cylinders, however, some staff were yet to complete the British Oxygen Company (BOC) online training, for the operation of the oxygen cylinders. We were told that the lead nurse intended to ensure training was carried out at the next nurse team meeting.

The practice must ensure that all relevant staff complete the online training for the operation of the oxygen cylinders.

There was appropriate resuscitation equipment and emergency drugs in place to manage a patient emergency, such as a cardiac arrest. These met the primary care equipment standards as outlined by the Resuscitation Council UK guidance. Staff were aware of the location of the equipment which was clearly signposted. This included the automatic external defibrillator (AED), which was available with age appropriate and in date pads, as well as a spare battery. There were clear audit processes in place for the regular checking and replacement of all resuscitation equipment, consumables and relevant emergency drugs, including oxygen. An up-to-date resuscitation protocol and flowchart was kept within the resuscitation equipment for ease of accessibility.

Staff had completed appropriate training for medical emergencies and all clinical staff had undertaken appropriate basic life support training.

Safeguarding of children and adults

The practice policies, procedures and culture ensured that people and staff were able to report safeguarding concerns. Safeguarding issues were appropriately investigated, and action taken where necessary to protect the welfare of vulnerable children and adults. In addition to appropriately following the Wales Safeguarding Procedures, there was a local safeguarding policy in place to direct staff where and how to locally raise any safeguarding concerns.

Any child who was subject to the child protection register would be coded in the practice records. This allowed the clinicians to identify children who were subject to the child protection register. Where there may be a safeguarding concern for a child and they were not located on the protection register, then the clinicians would follow the local procedure to raise their safeguarding concern.

The practice would also follow the Wales Safeguarding Procedures for adults at risk of abuse. The practice had a system in place to identify those at risk by flagging them on their clinical record system. There was also a process for removing the marker when the child was no longer considered to be at risk.

One of the GPs was the nominated safeguarding lead for children and adults. Staff knew who this was and how to report any safeguarding concerns. There were quarterly safeguarding meetings which were minuted. An example of a safeguarding concern was discussed with us, which demonstrated good inter-agency working.

The sample of five staff training records checked showed that staff were up to date with safeguarding training (adult and child).

Management of medical devices and equipment

The practice had processes in place to safely maintain equipment. Single use disposable equipment was used whenever possible. There were contracts in place for maintenance and calibration as appropriate, and for any emergency repairs and replacement. We found all equipment was in a good condition, well maintained with appropriate electrical checks carried out.

There were appropriate arrangements for the collection of clinical waste bags by an external company. The external cleaning team employed by the practice, arranged disposal of the clinical waste bags.

Effective

Effective care

There were processes in place to support safe and effective care and the practice had links with the wider primary care services.

Should a patient contact the practice for emergency care, instead of 999, the care navigation team were aware of the requirements of emergency care. There was a written care navigation pathway in place, and all administrative staff completed the care navigation training.

Any patient test results would be followed up and provided within a face-to-face consultation with the GP on duty for that day, in relation to any changes to medication or care.

Most patient referrals to specialist services were submitted via the Welsh Clinical Communications Gateway (WCCG). Sessional and locum GPs were made aware of the referrals process in use at the practice, through a file on the shared drive detailing the referral processes. The practice used the same group of locums who had previously been trainees at the practice and were familiar with staff and procedures.

The practice ensured that the patients requiring mental health support were appropriately signposted and supported. The process for supporting people who had contacted the practice in mental health crisis was described to us, and patients were signposted from reception to the GP who managed acute emergencies of the day. The practice could access relevant services available for people in crisis or increase of their mental health needs. These included NHS Direct 111 option 2, Silvercloud, an online therapy course, and MIND, a charity that provides information, advice and service for people with mental health problems. Patients could also access the Powys Association of Voluntary Organisation (PAVO), a mental health service for patients in Powys. Leaflets for this service were available in reception.

The practice nurses ran asthma, diabetes management and chronic obstructive pulmonary disease (COPD) reviews. The pharmacist also completed asthma and COPD reviews, and the physician's associate (PA) carried out hypertension and learning disability reviews. The PA always had a GP overseeing their work, who also reviewed their consultations.

Patient records

We reviewed a sample of ten electronic patient records. They were clear, written to a good standard and complete with appropriate information. They were contemporaneous and were easy to understand by other clinicians reviewing the records. These were stored securely and were password protected from unauthorised access.

It was positive to note that acute assessments included a recording of five basic observations pulse, blood pressure, respiratory rate, temperature and oxygen saturation. Read Coding was good in general, but minor illnesses were not being coded in the patient records.

The practice must ensure that minor illnesses are Read coded in clinical records.

The quality of patient records for chronic disease management (CDM) was good. The process included GP medication reviews, blood tests as appropriate and a patient would be booked for the CDM review with the practice nurse. Each morning before clinics began the CDM lead GP for the day met with the nurses and discussed patients booked and agreed management action. If issues arose during consultation, eg blood pressure was too high, this was discussed with the GP who adjusted the treatment whilst the patient was still in the surgery. We found a low number of CDM reviews, however, this was found to be an issue of coding and recording of the CDM reviews, and the practice agreed to use a READ code for these reviews to capture all clinical care.

Regular prescribing audits were undertaken at the practice by the local prescribing team. The most recent identified five areas of prescribing that the GPs needed to review.

Efficient

Efficient care

Senior staff spoke about Red Kite Health Solutions, set up as a community interest company by the GP cluster to provide services through a medical services contract with the local health board. This enabled the practice to obtain quick point of care testing (blood), for C-reactive protein (CRP), to help determine whether a patient had an infection and help reduced unnecessary antibiotic prescribing. The practice also screened for atrial fibrillation symptoms during vaccination clinics and provided a pain management service for patients.

Quality of Management and Leadership

Staff feedback

We received one response to our staff survey. Therefore, we could not identify any themes or trends, however, the response was overall, positive.

Leadership

Governance and leadership
There were processes in place to support good governance, leadership and accountability, to ensure sustainable delivery of safe and effective care.

Staff and managers were clear about their roles, responsibilities, reporting lines and the importance of working within their scope of practice. We saw up to date job descriptions for staff and organisational charts, which were given to all new starters on induction. The responsibilities for management, administration, accountability and reporting structures within the team were clearly defined and were understood by team members.

Meetings were held with team leaders and minutes and actions were completed and were disseminated to their teams. In addition, any changes to policies or procedures following their review were also discussed with and sent via email. Clinical information was also shared in the practice through regular meetings, which were minuted and shared as appropriate.

Senior staff we spoke with felt the main challenges and pressures they faced was the impact on staff mental wellbeing following the COVID-19 pandemic. Staff were supported through flexible working and an open-door policy was in place to support staff.

All policies and procedures were located on the shared drive and all staff were emailed when changes occurred. However, the policies and procedures in place were not all version controlled.

The practice must ensure that all policies and procedures are all version controlled, contain a policy author and have implementation date and review dates.

Workforce

Skilled and enabled workforce

The practice had enough staff with the right knowledge and skills available at the right time to meet demand. There was clear evidence that staff had undertaken all mandatory training except for portable oxygen cylinder training as highlighted earlier.

Staff were supported to complete training relevant to their role. Records were kept of mandatory and all other training, such as injection techniques, immunisation training and wound management. Some staff had also completed leadership training.

Staff described the process for recruitment and conducting pre-employment checks. This included a Disclosure Barring Service (DBS) check and references. For clinical staff, checks of their professional's registration were also completed with their regulatory body. The staff files demonstrated the relevant process had been followed and were complete.

The practice had an employee handbook compiled by an external human resources company, which included policies related to recruitment, an equality, inclusion and diversity policy, data protection policy and health and safety rules.

There was evidence of individual scope of practice which had been reviewed for the new non-medical prescriber and lead nurse including a period of training and supervision specifically relating to minor illness clinics. The lead nurse was considering increasing their scope of practice to include a Master of science degree in advanced practice.

There was a workforce plan in place to maintain appropriate capacity and skill mix daily. The plan was reviewed annually as part of the practice development plan.

Culture

People engagement, feedback and learning

Staff demonstrated how they acted and learnt from any patient feedback, through the process in place which captured the information on specific forms. Lessons learned and action plans were implemented, and the details were shared with all staff.

A suggestion box was available in the patient waiting area, for patients to provide feedback or make suggestions about the practice.

The complaints policy in place aligned with the NHS Wales Putting Things Right procedure and both were displayed in the waiting room. If a patient wanted to make a complaint, senior staff said they would initially aim to resolve the concern

informally. If unresolved, the complaint would be managed in line with the practice complaints process. A spreadsheet was maintained with details of the complaint and any action taken. The practice had identified a theme in the complaints received, relating to the telephone system. As a result, the telephone system had been recently changed, with additional telephone lines added.

A Patient NHS Experience survey had been undertaken in line with the General Medical Services (GMS) Wales Contract. The survey was available to patients in English and Welsh, in both paper format and electronically. The results were not displayed on the website nor at the practice. These were reviewed by practice staff along with the short, medium and long-term action plan in place, to make improvements following the feedback received.

In our patient's survey, none said that they had been asked by the practice about their experience of the service provided and few knew how to complain about the service.

The practice must consider how patients survey results are fed back to patients.

From speaking with senior staff, they understood their responsibilities under the duty of candour. We were told that staff had also received duty of candour training. However, the practice did not have a duty of candour policy in place, but used the local health board duty of candour guidance.

The practice must ensure that there is a duty of candour policy written which is specific to the practice.

We considered whether staff received annual appraisals and there were no records in place to demonstrate staff appraisals had been carried out at the practice.

The practice must ensure that staff personal annual appraisals are conducted on an annual basis and a record is maintained in their staff file.

Information

Information governance and digital technology

The practice understood its responsibilities when processing information and demonstrated that personal data was managed in a safe and secure way and a current information governance policy was in place. There were effective arrangements in place to ensure that personal or confidential data was shared to external bodies securely when required.

The process for handling personal data was highlighted to patients on the practice website and a notice was also available in the waiting room. The practice used the Digital Health and Care Wales (DHCW) service to support the data protection officer, who was also the information governance lead.

Learning, improvement and research

Quality improvement activities

The practice engaged with audit and quality improvement, to ensure people received a safe and good quality service. Clinical audits were completed by the GP and trainee GPs to monitor quality. The results were presented at clinical meetings and any learning was shared across the practice to make improvements. Senior staff also told us that the practice engaged in mortality reviews of care home patients on a quarterly basis and would also attend local hospital mortality reviews on request.

Whole-systems approach

Partnership working and development

As highlighted earlier, the practice managed a virtual ward of patients who needed care at home. The process was described and those involved included, community resource team doctors, the home visit doctor and district nurses. Weekly multidisciplinary team (MDT) meetings were held and included social services and reablement teams. Palliative nurses and Macmillan nurses also attended the MDT meetings monthly.

The practice was an active member of the South Powys GP cluster and one of the GP partners were designated the cluster lead.

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 on this inspection			

Appendix B - Immediate improvement plan

Service: Brecon Medical Group Practice

Date of inspection: 17 September 2024

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	Standard / Regulation	Service action	Responsible officer	Timescale
1.	The inspection team were not provided with evidence that the practice can assure itself regarding the Hepatitis B immunity status of clinical staff, to protect themselves, those they are close to and work with, and people attending the practice for clinical consultations or care. During our inspection we found that the	The practice must ensure that: • A Hepatitis B immunity register is implemented, to record the immunity status of the clinical staff. • Staff provide evidence to the practice manager of their immunity status.	Health and care Quality Standards 2023 - Workforce - Risk Management Immunisation against infectious disease (The Green Book) 2006 - Chapter 18	A register will be created on the practice share drive (password protected) of all clinical staff. This will contain details of proof of immunity (antibody titre and date), date of primary courses, and the date of any subsequent boosters. ACHIEVED A review of each clinicians HR file will be undertaken and where possible, evidence of Hep B Immunity will be taken	Sandra Thomas (HR Manager)/ DR Anthony Morgan Lead GP Infection control. Sandra Thomas/ Dr Anthony Morgan	Immediate - this action has been completed. 12 GP`s, 1 PA, 11 Members of nursing team Immediate - this action has been completed. 9 Clinicians

	practice did not have recorded evidence regarding its clinical staff and their Hepatitis B immunity status. We were told that evidence was checked by the General Practice (GP) partner lead for Infection Prevention and Control (IPC) for staff before they started working at the practice. However, evidence of immunity was absent.	• Risk assessments are undertaken, and action implemented where applicable, for staff who are unable to demonstrate immunity following Hepatitis B vaccination.		from this and placed on the register. ACHIEVED Those clinicians who do not have documented evidence of Hep B immunity on file will be contacted and asked to provide as soon as possible. ACHIEVED The necessary documentation will be reviewed by Infection Control Lead (Dr Morgan) and the results placed on the register. Those who do not demonstrate adequate immunity will be further risk assessed and action taken as per green book. This could involve a repeat primary course, a booster, or a repeat antibody test. ACHIEVED	 Sandra Thomas/ Dr Anthony Morgan Dr Anthony Morgan	have documented evidence of Hep Immunity in HR files. 72 hours 7 days

				Those who cannot provide documented evidence of immunity will be asked to have an antibody test either at the practice or with their own GP to provide an up-to-date antibody titre. ONE MEMBER OF STAFF SOURCING VACCINE INFORMATION FROM HEALTH BOARD (PREVIOUS EMPLOLYER)	Dr Anthony Morgan/ Sandra Thomas	2 weeks
				These results will be acted upon by the infection control lead (as per Green Book) and results placed on central register. Clinicians may require a further course of Hep B vaccine, a booster or an individual risk assessment. ACHIEVED	Dr Anthony Morgan	One month.
				The completed register will allow us to identify those clinicians who have not demonstrated immunity to Hepatitis B. They will have a	Dr Anthony Morgan/ Sandra Thomas	This will be ongoing but will start within 2 weeks.

				risk assessment of their role undertaken by HR and Infection Control Lead. If it is not possible to remove their risk (i.e. GP/ nurse non responder) we will discuss an individual risk management and plan, should they be exposed to Hepatitis B. This may involve an immediate booster and / or Hep B Ig depending on the level of risk. The central register will indicate these cases, and a copy of the management plan will be placed in the staff HR file. ACHIEVED		
				All new members of the clinical team will be placed on the central register. They will be asked for proof of Hepatitis B immunity and vaccination status as part of the pre-employment check. This will be forwarded to the infection control lead for review. Should there be concerns about	HR Manager/ Infection Control Lead – currently Sandra Thomas and Dr Anthony Morgan	Start immediately, ongoing for new members of staff.

				immunity a plan will be implemented and communicated to the clinician before they start work. ACHIEVED The register will be reviewed on a 6 monthly basis to ensure all clinical staff have up to date information and suitable management plans in case of Hepatitis B exposure. ONGOING PLAN	Dr Anthony Morgan	Review of register every 6 months.

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): **Dr Anthony Morgan**

Job role: **GP**

Date: **21 October 2024**

Appendix C - Improvement plan

Service: Brecon Medical Group Practice

Date of inspection: 17 September 2024

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	Standard / Regulation	Service action	Responsible officer	Timescale
1.	Whilst some telephone conversation could be overheard in reception, we were told that no patient identifiable information would be discussed. However, only 17% of patients said that they could talk to	The practice must ensure that all patients conversations, including telephone conversations, are private to ensure the privacy of all patient issues.	Dignified and respectful care	Information to be made available to patients to indicate that if a patient wishes to speak to someone regarding a confidential matter, steps will be undertaken to facilitate this. Team training will be made available and included in the team induction packs.	Practice Management Team & Reception Team Leaders	Immediate

	reception staff without being overheard.					
2.	The practice offered both male and female chaperones in all appropriate circumstances and there was a chaperone policy in place. However, whilst there was a sign in reception saying that chaperones were available on request, there was not a notice in each clinical room.	The practice must ensure that there is a chaperone availability notice displayed in each consultation and treatment room to advise patients of the service.	Dignified and respectful care	All clinical rooms to display information in the form of a poster informing patients of practice Chaperone Policy.	Health & Safety Lead & Practice Nurse Team Leader	Immediate
3.	We were told that there were	The practice must ensure that	Communication and language	"Active Offer" Information to be displayed in the patient waiting room	Practice	2 months

	no Welsh speaking members of staff at the practice, and staff were not aware of the 'active offer', which meant providing a service in Welsh without someone having to ask for it. Additionally, most information on display was only available in English.	• All staff are made aware of the 'Active Offer' in Wales, to provide services in the medium of Welsh and to facilitate this using translation services where appropriate, in the absence of Welsh speaking staff • More bilingual information is available for patients using the practice.		and practice teams to receive updates on the service. Practice Welsh Speakers to have a Badge and lanyard to identify them to patients. Practice to utilise the Translation Services from Powys Teaching Health Board to have important patient information translated for publication. Continue to use the Welsh Interpretation and Translation Service (WITS) to any support patients requesting a translator.	Management Team	
4.	Regarding access to the practice, most patients said	The practice must reflect on the patient feedback in this report and consider	Communication and language	The Practice undertakes regular updates of its Practice website and uses text messaging to alert patients to its opening hrs.	Practice Management Team & Governance	- Ongoing

	they were satisfied with the opening hours, with few saying they could not contact the practice when needed. For patients with an ongoing medical condition, again, few said it was not easy to access the regular support they needed. Most patients said they knew how to access out of hours GP services, if they could not wait until the practice was open.	what improvements can be made to address the less than positive feedback, such as access to appointments, contacting the practice for support when needed and for ongoing medical conditions.		The practice has procured an upgrade of its automated arrival (booking in) terminal and calling boards which will support the publishing of practice access information. Practices in South Powys Cluster are working collaboratively and developing improvements of its use of text communication by the use of the platform – AccuRx. This platform along with the practice website will be used to alert patients to important service changes The GP partnership meetings will continue to diarise a regular agenda item to review and reflect on changes to its appointment model, Patient concerns and complaints.	Lead - Dr James Lloyd	

5.	All patients said their identity was checked, such as date of birth and address during appointments. Only 57% said their allergy status and ongoing medical conditions were checked prior to the GP prescribing new medications, 63% felt they had enough time to explain their health needs and 88% felt they were listened to.	The practice must ensure that clinical staff check a patient's allergy status prior to prescribing new medication.	Communication and language	The practice will undertake a review of its induction packs for new and visiting clinicians and include an update of their responsibilities when identifying and coding allergies for patient safety and effective medication management purposes.	Governance Lead - Dr James Lloyd	Within next 2 months
6.	There were disposable privacy curtains	The practice must ensure that all the disposable privacy	IPC	The practice will endeavour to review and adhere to its current Infection	Health & Safety Lead – Dr Anthony	Immediate

	in place in one consultation room, one of which was dated as in place in 2023. The disposable privacy curtains in patient treatment areas should be changed and dated on a six-monthly basis or sooner if soiled.	curtains used in treatment and consultation rooms are replaced every six months or sooner if soiled.		Control polices and review as appropriate. The practice can confirm that there is a current disposable curtain policy in place and active.	Morgan & Practice Nurse Team Leader – Nurse Parbati Shrestha	
7.	The practice had two non-medical prescribers. However, there was no formal processes in place to review and oversee the competency of non-medical prescribers.	The practice must ensure that a formal process is implemented to review and oversee the competency of non-medical prescribers.	Medicines management	All Independent prescribers will have a mentor and meet annually, discuss their area of prescribing formulary and provide and annual audit.	Governance Lead – Dr James Lloyd & Mentors	Within next 6 months

8.	We were told that all clinical staff were aware of how to operate the cylinders, however, some staff were yet to complete the British Oxygen Company (BOC) online training, for the operation of the oxygen cylinders.	The practice must ensure that all relevant staff complete the online training for the operation of the oxygen cylinders.	Medicines management	All Clinicians will be reminded of the importance of clinical update and training. Training matrix to be checked and clinicians who have not completed and submitted certificates followed up.	Health & Safety Lead – Dr Anthony Morgan	Within the next 2 months
9.	Read Coding was good in general, but minor illnesses were not being coded in the patient records.	The practice must ensure that minor illnesses are Read coded in clinical records.	Patient records	The practice will undertake a review of its induction packs for new and visiting clinicians and include an update of their responsibilities when identifying and coding allergies and illnesses for patient safety and effective medication management purposes.	Governance Lead – Dr James Lloyd	Immediate

10.	All policies and procedures were located on the shared drive and all staff were emailed when changes occurred. However, the policies and procedures in place were not all version controlled.	The practice must ensure that all policies and procedures are all version controlled, contain a policy author and have implementation date and review dates.	Governance and leadership	The practice to review its policy structure and develop a central portfolio of policies and procedures. Continue to identify them at induction into the practice and review in accordance with appropriate timescales.	Governance Lead – Dr James Lloyd	Ongoing
11.	In our patient's survey, none said that they had been asked by the practice about their experience of the service provided and few knew how to complain	The practice must consider how patients survey results are fed back to patients.	People engagement, feedback and learning	Information is published on the practice web site and the practice will continue to review and develop this communication and include information where possible in alternative forms.	Practice Management Team & Governance Lead - Dr James Lloyd	Within the next 2 months

	about the service.					
12.	The practice did not have a duty of candour policy in place, but used the local health board duty of candour guidance.	The practice must ensure that there is a duty of candour policy written which is specific to the practice.	People engagement, feedback and learning	The practice is to implement a Duty of Candour policy to run alongside its current protocol and procedures. All practice team colleagues to be advised where to access it for future reference.	Practice Management Team & Governance Lead - Dr James Lloyd	Immediate
13.	We considered whether staff received annual appraisals and there were no records in place to demonstrate staff appraisals had been carried out at the practice.	The practice must ensure that staff personal annual appraisals are conducted on an annual basis and a record is maintained in their staff file.	People engagement, feedback and learning	Our process going forward will be to provide two hard copies of Appraisal – one for staff member retention and the other for the personnel file.	Practice Management Team & Governance Lead - Dr James Lloyd	Ongoing

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): **Dr Anthony Morgan**

Job role: **GP**

Date: **5 November 2024**