Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

General Practice Inspections

Pilot 2014-15

Thematic Analysis

May 2015

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.
Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163
Email: hiw@wales.gsi.gov.uk
Fax: 0300 062 8387
Website: www.hiw.org.uk

Digital ISBN 978-1-4734-3671-8

Contents

1. What we did? (scope)

Healthcare Inspectorate Wales (HIW) completed a pilot year of inspections of General Practice (GP) during 2014-15.

Each inspection was announced and was conducted by a team which included an inspection manager from HIW, at least one external reviewer (a GP or practice manager with recent hands on experience) and, for most inspections, a member of the local Community Health Council (CHC).

During each inspection we considered and reviewed the following areas:

- Patient experience
- Delivery of Standards for Health Services in Wales
    - Communicating effectively
    - Records management
    - Dealing with concerns and managing incidents
- Management and leadership
- Quality of environment.

2. Why we did it? (background and purpose)

In 2013, HIW decided to introduce an inspection programme of GP practices. HIW sought to devise an appropriate inspection programme that:

- Fulfils public assurance of GP services
- Adds value to quality monitoring exercises already in place and drawing on them, minimising duplication and overlap as far as possible.

In order to develop an effective approach, HIW chose to pilot the inspection programme in 2014 -15. HIW chose to use a themed approach for the pilot inspections. The theme was informed by the case of Robbie Powell.

In October 2012, the Welsh Government published their response to the independent investigation into the death of Robbie Powell, a 10 year old boy who died in 1990 from Addison's disease. The document, called *'Learning for the future – Taking forward and building on recommendations from the Robert Powell investigation* [1]*',* made recommendations which were categorised into four main themes. HIW chose to examine these themes. They are:

- Communication and involvement with patients and their families
- Accessing and managing medical records
- Improving communication to ensure continuity of care
- Dealing with concerns and complaints following the death of a patient.

In order to examine these themes, we focussed in detail on how the GP practice meets the following standards:

- Standard 18 - Communicating effectively
- Standard 20 - Records management
- Standard 23 - Dealing with concerns and managing incidents.

[1] Both the independent report and the response of the Welsh Government can be accessed from the following link: http://wales.gov.uk/topics/health/publications/health/reports/powell/?lang=en

3. How we did it? (methodology)

HIW inspections of General Medical Practices (GP surgeries) sought to establish how well GP practices meet the standards in *Doing Well, Doing Better: Standards for Health Services in Wales*[2].

We established a reference group to obtain the views of a range of stakeholders who would challenge and support the development of the project. It consisted of representatives from GPs, nurses, practice managers, health boards, Welsh Government, Public Health Wales and CHCs. The group provided feedback on HIW's plans as the programme developed to ensure that the inspections were credible and fit for purpose.

We recruited external reviewers (GPs and practice managers) who have recent hands on experience of working in general practice to ensure the inspections were relevant to current practice.

Workbook

We designed an inspection workbook to independently test the service actually provided to patients by their GP. We identified existing information and self assessment tools to reduce the burden for GPs and add value to those exercises currently in use.

Many GP practices are familiar with the All Wales Clinical Governance Practice Self Assessment Toolkit (CGPSAT) produced by Public Health Wales. The CGPSAT is mapped to the *Doing Well, Doing Better: Standards for Health Services in Wales* and aims to help GP surgeries to meet these standards. It "*encourages practices to bridge the gap between understanding and thinking about their governance systems and completing the actions needed to improve them*[3]".

HIW designed its inspection tools with reference to the information contained within the CGPSAT to ensure that inspections are relevant to current issues in GP practice.

---

[2] *Doing Well, Doing Better: Standards for Health Services in Wales* was a framework of standards which set out the requirements of what was expected of all health services in all settings in Wales. These standards were in place from 1st April 2010 until 31 March 2015. These Standards have since been replaced by the Health and Care Standards, which came into force from 1st April 2015.

[3] http://www.wales.nhs.uk/sitesplus/888/page/44038#A

The pilot year

The pilot GP inspection project was split into two phases:

Phase 1 – June – July 2014

We conducted a concentrated inspection of 11 practices in Cwm Taf University Health Board. We worked with Cwm Taf University Health Board to identify a range of practice sizes, allowing us to test our processes in a range of settings. This phase of the inspection programme allowed us to learn about the inspection methodology and to test the composition of our inspection teams. We also used this phase of the pilot to establish how best HIW could work in a collaborative and complimentary way with CHCs, who already conduct site visits to GP practices, to ensure that the inspections captured what patients think about their GP practice.

Following Phase 1 of our pilot, we concluded that all inspection teams should include a GP external reviewer, and when inspections of larger practices took place, our inspection teams should also include a practice manager. All inspections were led by an inspection manager from HIW.

Phase 2 – September 2014 – January 2015

We rolled out the pilot across Wales. We conducted inspections of three to four GP practices in each health board to confirm that our inspection process works throughout Wales. We picked practices by practice list size, inspecting one large practice, one small practice and either one or two medium size practices in each health board.

Inspection methodology

During the inspection we reviewed documentation and information from a number of sources including:

- Information held by HIW
- Interviews of staff including doctors and administrative staff
- Conversations with nursing staff
- Examination of a sample of patient medical records
- Scrutiny of the policy and procedure associated with complaint handling
- Information within the practice information leaflet and website.

In order to ascertain the patient experience of the practice, members of the CHC held discussions with patients in the waiting room on the day of inspection. The members used a standard questionnaire as the basis for their discussion, to ensure consistency across all the practices we inspected.

At the end of each inspection, we provided an overview of our main findings to representatives of the practice to ensure that they received appropriate feedback. We then provided them with a draft report for them to check for factual accuracy. This report included, where necessary, an improvement plan for the practice to complete, to inform us how the issues identified would be remedied. Once the improvement plan had been evaluated the report was finalised.

Final inspection reports from this pilot were not published but were sent to the practice and the local health board, so that appropriate action could be taken to make improvements where these were identified. A copy of the report was also provided to the local CHC.

4. What did we find?

Summary

On the whole we found that patients were very satisfied with the care and treatment they receive from their GP practice and are very complimentary about the staff. Patients reported that they were generally happy with the opening times of their surgery. However, across Wales we found that access to appointments was an issue for patients.

We found that practices could engage better with patients about their appointment system, to educate patients as to what systems are in place, and to obtain feedback from patients. In this way, practices could ensure that their systems are as effective as possible.

We found that communication with patients could be improved. The provision of information in a range of formats, addressing language and communication needs, had not been considered by most practices. In order to cater for the entire patient population, this should be addressed. We were told by many practices that patients with additional needs "*usually attend with a carer*". This is not sufficient and healthcare should be independently accessible for all patients where possible.

The sharing of information between GPs and hospitals should also be improved, so that the patient is provided with greater continuity of care. We saw that when a GP refers a patient to hospital, this process usually works well. We were told that efficiency has been improved since the introduction of an electronic system. However, we found that communication between hospitals and GPs when a patient is discharged from hospital is generally inadequate. We saw evidence of discharge notices from hospitals of very poor quality. We were told that this has been an issue for many years. The expectation of patients is that information is passed from hospital to practices quickly and legibly. Practices alone cannot resolve this problem. It would appear to be a systemic issue which will require the support of secondary care and wider stakeholders to improve. It is vital to the continuity of care of patients and for patient safety that accurate and timely discharge information is received by general practice. The wider use of electronic discharge notices across hospital wards would improve the continuity of care for patients who have been treated in hospital and require ongoing care in the community.

Patient records were generally easy to understand, contemporaneous and recorded in sufficient detail to provide the patient with continuity of care if they were seen by a different clinician. We found that records were stored safely and were maintained securely.

GP practices we inspected handled formal complaints in accordance with the national arrangements for NHS complaints known as Putting Things Right[4], but did not usually record informal or verbal complaints. GP practices could improve the way they learn from concerns and complaints if they kept a record of all concerns received because trends or themes could be identified and addressed.

We found that GP practices were mostly run with suitable management systems. We found that in many practices, no formal staff appraisal system was in place to provide staff with an opportunity to discuss their training and support requirements.

The majority of practices were well maintained and accessible to wheelchair users, but this could be improved with greater use of automatic doors.

[4] http://www.wales.nhs.uk/sites3/home.cfm?orgid=932

Patient experience

On the whole, we found that patients were very satisfied with the care and treatment they receive from their GP practice and are very complimentary about the staff. Patients reported that they were generally happy with the opening times of their surgery. However, across Wales we found that access to appointments was an issue for patients.

We found that practices could engage better with patients about their appointment system, to educate patients as to what systems are in place, and to obtain feedback from patients. In this way, practices could ensure that their systems are as effective as possible.

We found that patients sometimes had to wait beyond their allocated appointment time, but the majority of patients did not mind this too much as they told us they were happy with the service once they were seen. We received comments such as:

> *"They are all amazing here and go out of their way to put patients first."*
>
> *"The staff at the surgery are of a very high standard and also go beyond to provide the best care possible."*
>
> *"Couldn't get better treatment."*
>
> *"Long waiting time for appointment."*
>
> *"It is difficult to get an appointment but sit and wait clinic is easy."*
>
> *"Getting through to make an appointment is very stressful."*

Despite the fact that patients reported that they were generally happy with the opening times of their surgery, across Wales we found that access to appointments was an issue for patients. We spoke to many patients who felt that it was difficult to book an appointment. Most practices operated an appointment system which was dependent on patients telephoning the surgery at between 8am and 9am for same day appointments. Patients told us that this was unsatisfactory as it was difficult to get through at this time. We heard from many patients that they found it difficult to get through after 8am as the line was engaged and that once they did get through, there were no appointments left.

Most practices acknowledged the difficulty in devising an appointment system which suited all patients. Many had tried different approaches to ensure that patients were seen by the most appropriate member of the clinical team, including reception staff being trained to ask questions of patients seeking to book appointments. Some patients told us that they did not like this approach as they felt that it compromised

their confidentiality. A few practices had been successful with this approach by educating the patient population as to why these questions were asked.

We explored the availability of routine appointments and discovered that many patients experience a long wait to see the doctor of their choice. We explored whether it was easier for patients to get appointments if they were prepared to see any doctor and in most cases we found that routine appointments were available.

We found that practices could engage better with patients about their appointment system, to explain difficulties and educate patients as to what systems are in place, and to obtain feedback from patients. In this way, practices could ensure that their appointment systems are as effective as possible.

Communicating effectively

We looked at how practices communicate with all their patients (including those with additional needs) and how patients could communicate with the practice; the mechanisms in place for internal communication; and how the practice communicates with other agencies such as hospitals. We found that most practices could do better in these areas.

Communication with patients and their families

We found that practices were good at communicating verbally with patients who attended at the surgery. Practice staff generally knew patients who attended regularly, and adapted their systems for those patients they knew had additional needs. For example, one practice which used electronic 'check-in' for patients told us they were aware of their patients who could not read and the receptionist would automatically check those patients in when they arrived. However, we found that most practices had not considered the communication needs of all patients, such as those with a learning disability, those whose first language is not English, or those who were new to the practice and whose needs were unknown.

Most practices we visited had a hearing loop system so that they could communicate with those with hearing impairment. However, we found that in some practices staff were not aware of the system and how it worked, and could not take action if the system stopped working.

Whilst some practices we visited had staff members who could speak Welsh and would communicate with patients in Welsh if requested, we did not find that the Welsh language was promoted in many of the practices we visited across Wales in accordance with *More than just words*[5].

All practices were aware of the Language Line scheme which supplies translation so that patients whose first language is not English or Welsh can understand their consultation, although we found some instances where the scheme was not used where it could have been.

Written practice information, such as the practice leaflet, was usually only available in English and was therefore not accessible to all patients. We found that some practices had considered alternative formats for their leaflet, for example some practices we visited had a leaflet available in Welsh and in large print. However, none of the practices we inspected considered providing this information in easy read format to assist those with cognitive impairment or those whose first language is not English.

---

[5] *More than just words* is a strategy developed by the Welsh Government to strengthen Welsh language services among frontline health and social services. http://gov.wales/topics/health/publications/health/guidance/words/?lang=en

We found that some practices did not have an up-to-date practice leaflet available, which is contrary to their General Medical Services (GMS) contract requirements.

All practices had a noticeboard which contained information for patients. Some practices had a dedicated noticeboard for carers, which was positive as they had recognised that carers often need specific support. We found that almost all information on noticeboards was in English, with some limited bilingual (English/Welsh) health promotion information displayed. We saw very few examples of accessible information in pictorial form, which would assist those who cannot read well in English.

We found that many practices did not review their practice information to ensure it remained up-to-date for patients. We also found that most practices had not considered how updates to practice information were relayed to housebound patients. Some practices told us that up-to-date information was only available on their website, but this did not cater for those without computer access or skills.

Most of the practices we inspected did not routinely seek any feedback from patients about the service they provide. We were told by many practice managers that they would happily receive verbal feedback from patients, but practices had limited mechanisms to receive patient feedback. We were told by many practices that they used to undertake patient questionnaires but no longer do so since this activity no longer attracts Quality Outcome Framework[6] (QOF) points. Individual GPs undertake patient questionnaires as part of their revalidation. Revalidation is the process by which doctors demonstrate they are up-to-date and fit to practise and happens every five years.

Some practices had a suggestions box or a suggestions book but there was limited evidence that the feedback received in this way was acted upon by the practice. Some practices had a patient participation group (PPG) which had proved a successful way of engaging with patients. No practice we inspected had considered gathering the views of patients who do not routinely attend the practice.

Internal communication

Communication internally within practices was generally good. Most practices had staff meetings, whether formal or informal and most practices had some sort of internal system to relay important messages about patients to ensure the patient received continuity of care. We found some practices which did not have a system for sharing information internally, for example so that staff were aware when a patient had died.

---

[6] The Quality and Outcomes Framework (QOF) is a system for the performance management and payment of NHS GPs in the UK. QOF is an annual reward and incentive programme detailing GP practice achievement results.

Most practices we inspected had regular team meetings of some kind. We saw small practices where the whole staff team met together on an almost daily basis, and we saw large practices where team meetings took place regularly, but the whole staff only met on an annual basis. Where practices held regular staff meetings we found that staff were clear about their role and generally felt supported. We found in some practices that communication between clinical and administrative staff could be improved.

Communication with other agencies

We looked at communication between GP practices and out of hours services, which are provided by the health board. All GP practices we visited had an email or fax system for alerting the out of hours system about patients about whom they are concerned, for example palliative care patients. We were told that if a patient is seen by the out of hours service, a record of their consultation is sent back to the GP practice usually by 9am the following day, so that it can be added to the patient notes and any follow-up action taken. GPs told us that this system generally works well.

We also looked at communication between GP practices and hospitals. We were told that the system for GPs to make referrals to hospital has improved across Wales as it is now mostly electronic. However, the mechanism for GPs to receive information from hospital is much more variable. Therefore, GPs are not always aware of the outcome of the referrals they make. Some hospitals and some wards in hospitals use paper discharge notices, which are handwritten on carbon copy paper by a doctor on the ward and then sent to the GP practice. GPs told us that these discharge notices are often very delayed, are often inadequate and illegible and sometimes do not contain patient identifying information. We saw evidence of this during our inspections. We also saw administrative staff at GP practices spending time telephoning the hospital to clarify the information contained in discharge notices. Almost all GPs told us that this system does not allow them to provide effective care for patients. There were some areas of Wales where hospitals provided electronic discharge notices and in these areas we were told the situation had improved greatly. However, even in these areas we were told that the timeliness of these notices could improve. The wider use of electronic discharge notices across hospital wards would improve the continuity of care for patients who have been treated in hospital and require ongoing care in the community.

We did see evidence of good working between GP practices and hospitals in Powys Teaching Health Board. We were told that practices had good links with the local District General Hospital and could refer patients directly to the x-ray department from the minor injuries clinic at the surgery, thereby removing the need for the patient to have initial assessment at A&E. The practice also had two beds at the local hospital to which the practice could admit patients and from where they would manage the patient's care.

Records management

We looked at a random sample of patient records for each GP or nurse consulter in each practice we inspected. Our GP reviewers examined patient records of surgery consultations, telephone consultations and home visit consultations. We found that in general, patient information was recorded contemporaneously, in understandable language, and in sufficient detail so that a following clinician could understand the consultation which had occurred. Sometimes we found that there had been a delay in the recording of home visits, and we raised this with the practices concerned as this could result in lack of continuity of care for patients.

We found that records were stored safely and were maintained securely.

All practices had a system to ensure that incoming patient information (for example from letters or emails) was added to patient records in a timely manner. We found that most practices had clear systems to ensure that when test results were received which required urgent action, appropriate action was taken.

All practices use READ codes[7] to summarise information in patient records. READ coding was usually done by administrative staff, but we found that in some practices there was no agreed set of common READ codes used. This means that the same condition might be coded differently by different staff.

We found that most practices did not routinely review the quality and consistency of their records to identify areas of improvement and share findings with the clinical team. This would aid learning and development and the practice team would be able to self identify areas for improvement in record keeping, thereby ensuring greater continuity of care for patients.

[7] READ codes are a set of clinical computer generated codes designed for use in Primary Care to record the every day care of a patient. READ codes record diagnoses, processes of care (including history, symptoms, examinations, tests, screening and operations) and medication. READ codes are a recognised standard for General Practice and assist GPs to understand the needs of their practice population. The codes also facilitate audit activity and reporting within primary care.

Dealing with concerns and managing incidents

We looked at how concerns and complaints are handled by practices. We checked whether the practice had a complaints policy, we looked at complaints files and logs, and we enquired about learning which took place as a result of complaints.

All but one practice we inspected had a complaints policy. This was not always compliant with the national arrangements for dealing with NHS complaints, (Putting Things Right). The most common issues we found were that the timescales for responding to patient complaints were not correct and the practice did not inform the patient about the assistance available through the CHC complaints advocacy scheme. Where the written procedure was compliant with the Putting Things Right guidance, we found that this was not always implemented where practices did not have standard response letters.

We found that some practices did not display their complaints procedure so that patients would know how to raise a concern. Practices should consider how their complaints process is accessible to all their patients, so that all patients are aware of their rights.

We found the majority of practices kept a record of written complaints. However, we found that most practices do not keep any record or log of verbal or informal complaints. This means that practices were not learning from those who do not wish to make a formal written complaint but nevertheless wished to feedback a negative experience to the practice. We recommended that practices should ensure that verbal formal complaints are accepted, recorded and managed in the same way as written complaints. We also recommended that practices implement a suitable system to record informal complaints. We advised that practices regularly review all complaints received so that themes and trends could be identified and service improvements made where necessary.

We found that learning from concerns and complaints could be improved in some practices, for example by discussion in team meetings. As some practices did not have a whistleblowing policy, we also found that some practices should consider how they ensure all staff are aware of their rights and responsibilities in escalating concerns about patient care, outside of normal channels and management structures, should the need arise.

We looked at significant events and found the procedure at most practices was adequate. We saw some examples of very good systems for reviewing significant events so that the staff team learned any appropriate lessons to avoid repetition of the event.

Management and leadership

We looked at the management processes within practices. During every inspection we spoke to staff undertaking different roles, for example we spoke to at least one doctor, one nurse, and one receptionist/administrative staff. Most practices we inspected across Wales were well run with clear lines of accountability and responsibility.

Where a practice covered more than one site, we looked at how the management was spread across the sites, and usually found this to be satisfactory.

We found that in many practices, no formal staff appraisal system was in place to provide staff with an opportunity to discuss their training and support requirements. We also found that some practices had not made time to allow staff to attend training opportunities. We recommended that these practices identify how and when staff could be released for training purposes, as this could improve the patient experience.

Quality of environment

During the inspections we considered the physical environment of the practice, and whether it was accessible to wheelchair users and those with additional needs.

Many of the practices we inspected operated from purpose built premises. Some practices were in need of redecoration, but all were generally well maintained, clean and tidy. Some practices had considered younger patients and had designated children's waiting areas. Some practices had designated car parking but many had no car parking nearby which could be an issue for patients with mobility difficulties.

We found that many practices were accessible for wheelchair users as the consultation rooms were at ground floor level and there was ramp access to the building. However, few practices had automatic doors to enable a wheelchair user to independently access the surgery. Some practices had considered this and had installed a bell for wheelchair users to ring, but this was often not well signposted or was out of the reach of wheelchair users. We found that not all practices had accessible toilet facilities for patient use, and not all practices had variable height seating for the comfort and safety of patients with mobility difficulties.

We found that in some practices the system used to alert patients when they have been called to their appointment was inadequate. For example, we found intercoms that were too quiet to be heard with no accompanying visual prompt. In some surgeries, the clinical staff entered the waiting room to call the patient and this appeared to work well as it ensured that patients did not miss their appointment. In one practice we observed that the preceding patient was asked to call the next patient for their appointment. Patients told us they were uncomfortable with this and we highlighted to the practice that this was inappropriate as it could breach confidentiality.

We saw some practices which had installed hand sanitisers in the patient waiting areas to help to reduce risks associated with infection control. However, hand sanitisers were not available in every practice. The provision of hand sanitiser gel in surgery waiting rooms might be positive to encourage good hand hygiene.

We noticed that in some practices, the internal signage could be improved as toilets and consultation rooms were not easily identified. We recommended that practices could consider pictorial signage to aid accessibility. We inspected one practice which had sought advice from agencies who work with people living with visual impairment about their signage. This was identified as good practice.

Most practices we inspected had suitable measures in place to prevent patient access to non patient areas such as record stores. However, some practices had unlocked doors which meant they could potentially be accessed by an unauthorised person. We advised the practices concerned accordingly.

5. Next steps

The pilot inspections of GP practices have been a success. The process has:

- Allowed HIW to test how the Standards for Health Services in Wales are being met
- Identified a number of areas where significant improvements have been made following the recommendations made in the Robbie Powell investigation
- Identified areas for GP practices to make improvements which will have positive outcomes for the delivery of patient care
- Enabled HIW to gain the benefits of working with Community Health Councils on inspections, with lessons being learned about how this can be improved in the future.

The GP profession has not been routinely inspected by HIW in the past and we are pleased that the majority of practices we inspected engaged well with the process. HIW encouraged feedback from practices who took part in the pilot and most considered it to be a fair, supportive and informative process which allowed them to learn and develop.

HIW plans to continue its inspection activity in General Practice and will continue to liaise with its stakeholder reference group for guidance as to relevant themes and issues to examine in future.