Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Gwirio bod pobl yng Nghymru yn derbyn gofal da

Checking people in Wales are receiving good care

Annual Report 2016 – 2017

General Medical Practices (GPs) Inspections

September 2017

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Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales are receiving good care.

Our values

- **Patient-centred: we place patients, service users and public experience at the heart of what we do.**
- **Integrity: we are open and honest in the way we operate.**
- **Independent: we act and make objective judgements based on what we see.**
- **Collaborative: we build effective partnerships internally and externally.**
- **Professional: we act efficiently, effectively and proportionately in our approach.**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care.**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice.**
Influence policy and standards:	**Use what we find to influence policy, standards and practice.**

1. Foreword

This is HIW's third annual report relating to the work we have done inspecting General Medical Practices (GPs) across Wales.

The purpose of this report is to summarise the findings from our inspections during 2016-17 and to highlight the areas for improvement and areas of good practice we have identified across services. As a result of the themes identified from our inspections, we have made overarching recommendations for services in this area (Appendix A).

HIW is responsible for the inspection of GP practices in Wales. Our inspections assess GP practices against the Health and Care Standards 2015 which provide the quality framework against which NHS service provision should be delivered. However, healthcare services themselves hold the primary responsibility for ensuring patients receive safe and effective treatment.

We expect that services working in this area will carefully consider the contents of this annual report and our overarching recommendations, using these to make improvements to their service.

2. Summary

We found that GP practices were working hard to provide safe and effective care. We identified much in the way of good practice across the sector. We identified a range of improvements needed across services and some of these, disappointingly, echo the recommendations we made in our 2015-16 annual report. This indicates that individual services, health boards and advisory bodies could do more to act on and share the learning from the recommendations we make within these reports.

During 2016-17, HIW conducted 27 inspections of GPs across Wales.

GP practices are responsible for meeting the Health and Care Standards 2015 and HIW assesses service delivery against this framework.

What we found practices did well:

Patients told us how much they valued the care they received from the team of staff at their GP practice.

We found that practices were working hard to try and meet the demand for GP appointments generated by their patients.

Practices had systems in place to try and ensure continuity of care when patients were being seen by different members of the team and to ensure that test results and other correspondence received about their patients was acted on promptly and incorporated into patient medical records as quickly as possible.

Practices were keen to develop the competence of their staff and invested in additional training as appropriate, for example nurse prescribing and minor illness treatment for practice nursing staff.

What we found practices could improve:

We found improvements were needed in the following areas:

- Practices need to ensure that their appointment systems are as accessible as possible to patients who may have additional needs. We found that sometimes the arrangements were restrictive as they only allowed bookings to be made in a certain way.
- Arrangements for ensuring that practices are aware of and fulfilling their obligations under Health and Safety law often needed strengthening.
- Arrangements for ensuring that policies and procedures are up-to- date and the latest versions clearly marked so that staff can be accurately guided in their duties.

We found that many practices had systems of initial patient triage and signposting in place in order to alleviate the demand for GP appointments and ensure that patients are seen by the most appropriate healthcare professional. However, patients often did not fully understand or accept the need for this. Practices were attempting to communicate this system, and the reasons for it, to patients, but health boards should consider whether they can support this with wider communication to help patients better understand why these systems are in place. In doing so, this will better support practices who are frequently challenged by patients in relation to this.

Reports on all of our inspections and their associated improvement plans are published on HIW's website.[1]

[1] www.hiw.org.uk

3. What we did

2016-17 was the third year of an ongoing programme of inspections to GP Practices across Wales. In total, we visited 27 practices across all seven health boards.

Each inspection visit was conducted by an HIW inspection manager, a HIW GP peer reviewer (a GP currently working in practice or recently retired), a HIW Practice Manager peer reviewer (a GP Practice Manager currently working or recently retired) and either Community Health Council (CHC) members or HIW lay reviewers.

All inspections were announced, with practices typically receiving between 6-8 weeks notice of their inspection date. This was so that the practice could make arrangements to minimise disruption for patients and so that the necessary personnel could be present at the inspection.

General practices themselves are responsible for ensuring the quality and safety of the care they provide. We explored how each practice met the standards of care set out in the Health and Care Standards (April 2015). The Health and Care Standards are at the core of HIW's approach to inspections in the NHS in Wales. Collectively they describe how a service should provide high quality, safe and reliable care centred on the person. The standards are key to the judgements that we make about the quality, safety and effectiveness of services provided to patients.

During each inspection, HIW considered whether there were effective systems and processes in place to ensure the service was:

- Meeting the relevant national standards and complying with regulations (those referred to above).
- Providing high quality, evidence based treatment and care through services that are patient/service user focussed.
- Continually monitoring the quality of treatment and services.
- Putting things right quickly, when they go wrong.

We published our findings within our inspection reports under three themes:

- Quality of patient experience.
- Delivery of safe and effective care.
- Quality of management and leadership.

During the inspection we gathered information from a number of sources including:

- Information held by HIW.
- Interviews with staff at the service.
- Conversations with patients and relatives (where appropriate).
- HIW patient questionnaires completed prior to inspection.
- Examination of a sample of patient records.
- Examination of policies and procedures.
- Observations of equipment and the environment.

At the end of each inspection, HIW provided an immediate overview of its main findings to representatives of the practice at a feedback meeting. Any urgent concerns regarding inspection findings, which could potentially pose an immediate risk to the safety of patients, were brought to the attention of practices and then via HIW's immediate improvement process. This involves the practice being sent a letter within two days of the inspection regarding the issues of concern (an immediate assurance letter), and the practice responding within one week to confirm that matters have been addressed.

A copy of this letter was also shared with the relevant health board and the healthcare quality division of the Welsh Government. Any other improvements identified were included in individual practice inspection reports, all of which are published on HIW's website. Our inspections capture a snapshot on the day of the inspection of the extent to which services are meeting essential safety and quality standards and regulations.

Following each inspection, the service was sent a draft report to check for factual accuracy. Where appropriate, this included an improvement plan for the GP practice to complete, in order to inform HIW of the actions being taken to address the issues identified. All improvement plans were separately evaluated by HIW to determine whether the service had responded appropriately or if further action was required. Once an improvement plan was agreed by HIW, it was published alongside the inspection report on HIW's website.

4. What we found

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

Overall, patients reported that they were very happy with the care they received from GP practices across Wales. We frequently heard that accessing appointments can be a huge challenge for patients and also for practices as they attempt to keep up with demand. All practices had recognised this challenge and many had put systems in place in an attempt to deal with the demand effectively, such as signposting patients to the most appropriate healthcare professional. However, patients were generally not happy with signposting systems, particularly when they involved reception staff asking questions during appointment booking conversations. Health boards should consider how they can support practices more in communicating this message to their patient population.

As part of the inspection process, GP practices were asked to distribute questionnaires to patients to obtain their views about the services provided. In some cases, the CHC were able to send these out ahead of the inspection, thus increasing the number of patients who were surveyed. Where the CHC did not conduct these inspections with us, HIW's own lay reviewers and questionnaires were used to gain patient views.

In general, the questionnaire responses received from patients were positive. Comments included the following:

"Rather pleasant experience of the NHS."

"Always helpful and professional."

"Very friendly staff and very understanding and relaxed."

Dignified Care

We looked at whether practices had considered the privacy of patients:

We consistently saw that practice staff treated patients in a polite, caring and friendly manner.

Consulting rooms were away from reception areas and we saw that doors were always shut during consultations in order to protect patient privacy and dignity.

Reception areas were noted at times to present a challenge to privacy of information for patients booking in; reception desks were mostly in the middle of waiting areas and people presenting for appointments or attending for other reasons had to provide some level of information in front of other patients. Practices were aware of this and all had some arrangement in place whereby patients could ask to speak to a member of staff in

a more private area. However, we saw that not all practices advertised this explicitly and patients may not therefore always be aware of this option, nor comfortable to request it. Practices should therefore consider their booking in and reception arrangements and devise solutions which will address the potential for lack of privacy in these areas. Where electronic booking in facilities are available, this can assist with maintaining privacy of patients, however this is not a suitable solution for all.

Practices all had chaperone arrangements in place for patients during a consultation, should they wish. However, we found that the extent to which this was made clear to patients, the robustness of the arrangements themselves and the recording of this within patient records was highly variable across practices. This was also found during our inspections in 2015-16. In nine out of 27 inspections, we were concerned enough about this finding to make it a formal recommendation for improvement. Practices and health boards will therefore need to consider the extent to which this message has previously been taken on board and shared, ensuring that it is not a continued failing at other practices in Wales.

We looked at the extent to which practices had considered the language needs of patients:

We explored how well practices were making provision for Welsh/English bilingual information to be made readily available to their patients. We also looked at how other language needs were being planned for and the extent to which they were being met.

We found that some practices were proactive in providing practice information in Welsh and in English, and also in other languages common to their patient population where appropriate. Some of the practices using electronic book in facilities at reception had ensured that this could be done in a variety of different languages. However, in the majority of practices visited, we highlighted that they could do more in this respect, from providing or increasing the amount of bilingual (Welsh/English) signage, to making bilingual information easily and readily available without the need for patients to ask.

We considered the provision for patients with additional needs:

Most practices had a hearing loop system for patients with hearing difficulties to use. However, we found some practices where the system was either not working, was not portable (so whilst it was available for patients in the reception area, it was not available in consultation rooms) or not all staff were aware of how to use it. We also saw that in some practices the signs on the wall were also in Braille. In general, practices could still do more to accommodate patients with additional needs, including considering whether options for booking appointments are as easy for patients with additional needs to access as those with no additional needs.

We looked at how practices provided information for patients:

All practices we visited had a patient information leaflet which provided patients with relevant and up-to-date information about the practice. In general, these were made routinely available in standard size print and in English. Practices told us that they could accommodate a request for Welsh leaflets, or large print if asked, but did not offer this routinely.

We also found that many practices had informative and up–to-date websites which provided information to patients about the practice and sometimes included useful links to health advice. One practice we visited was using QR codes[2] to provide practice information through smartphones. This was commendable and innovative practice.

Practices should also consider how they reach all their patients with practice information, including those who are housebound. In addition, language needs should be accommodated without the need for patients to ask for this.

Timely Care

Patients frequently told us that appointment systems were difficult to use and meant that they waited longer than they wanted before getting an appointment. In addition, the systems in place often meant that patients had to spend more time than they felt reasonable in order to make an appointment. Some of the comments received in this respect included the following:

> *"Booking appointment impossible. Frustrating not being able to see same Dr, especially with ongoing medical condition."*
>
> *"Appointments – can get one for the day but getting a routine appointment ahead is difficult."*
>
> *"Appointment times not long enough. Feel rushed out of the door each time, so not all problems discussed."*

We saw a variety of appointment systems in place, offering a range of on the day appointments, book-ahead appointments and emergency triage appointments. In some practices all appointments were open access and patients attended the surgery then sat and waited to be seen. Some practices offered the option of booking appointments on-line, whilst others offered a combination of on-line booking or telephone booking. The remainder of practices offered telephone booking only. Patients told us that they frequently found it very difficult to get through on the telephone and that once through, all available appointments may have gone, leaving them either to phone again the next day, access out of hours services, or even attend a nearby Accident and Emergency department.

Whilst practices were aware of these problems reported to us by patients, very often, they were unclear about what options they may have to improve the situation. We were told on numerous occasions that demand for appointments far outweighs the availability of GP or other healthcare staff time.

In a bid to ensure appointments were being allocated appropriately, many practices operated via a triage or signposting system, the intention of which was to allocate patients to the most appropriate healthcare professional – which might not always be a GP. However, patients were mostly not happy with this, feeling that it removes choice and they questioned whether triage starting at the point of receptionist staff is clinically appropriate. Whilst many practices have tried to communicate the reasons for the use of triage, it does not seem to be a topic

[2] QR codes, or Quick Response Codes, are 2D bar codes which are used to provide access to information, often through a Smartphone.

well understood or accepted by patients. In light of this, health boards, Welsh Government and other national bodies may wish to consider the need to support practices with a wider communication campaign to explain why triage and signposting are a common feature within General Practices.

Staying Healthy

We looked at how practices support carers:

Practices had a variety of arrangements in place to support carers registered at their practices. In some, we saw that there were dedicated noticeboards addressing carer's needs, or notices specifically intended for carers which were prominently displayed. Not all practices had dedicated carers' champions and where there were champions, the role was not always clearly defined and therefore potentially not used as effectively as it could be. We heard that some health boards offered dedicated training to help practices meet the needs of carers but we did not hear this consistently across Wales.

Individual Care

We looked at how practices ensure people's rights are upheld:

We checked a sample of patient records and looked at whether consent to treatment and investigations was being appropriately recorded. We also explored whether practices had made changes to consent policies, or had accounted for a recent court ruling about explaining risks to patients to ensure that their decision and consent has been fully informed (Montgomery judgement[3]). In general, patient notes demonstrated that consent was being sought appropriately, but on occasion, written policies could have better accounted for this latest clarification of the law.

We looked at how practices listen and learn from feedback:

Many practices provided a comments box in patient waiting areas to enable patients to leave comments and feedback. However, we frequently heard that these were seldom used. Some practices sought patient feedback through regular surveys; others had used patient surveys on occasion but did not use these as a regular mechanism.

Some practices had patient participation groups and told us that these were very active and useful. There did not seem to be a common approach to this and all practices should consider whether their systems of seeking patient feedback are sufficient and regular enough for them to remain properly aware of the views of their patients.

[3] The Montgomery Judgement has brought about a change to the law on informed consent. Doctors must now ensure patients are aware of any "material risks" involved in a proposed treatment and of reasonable alternatives. www.medicalprotection.org/uk

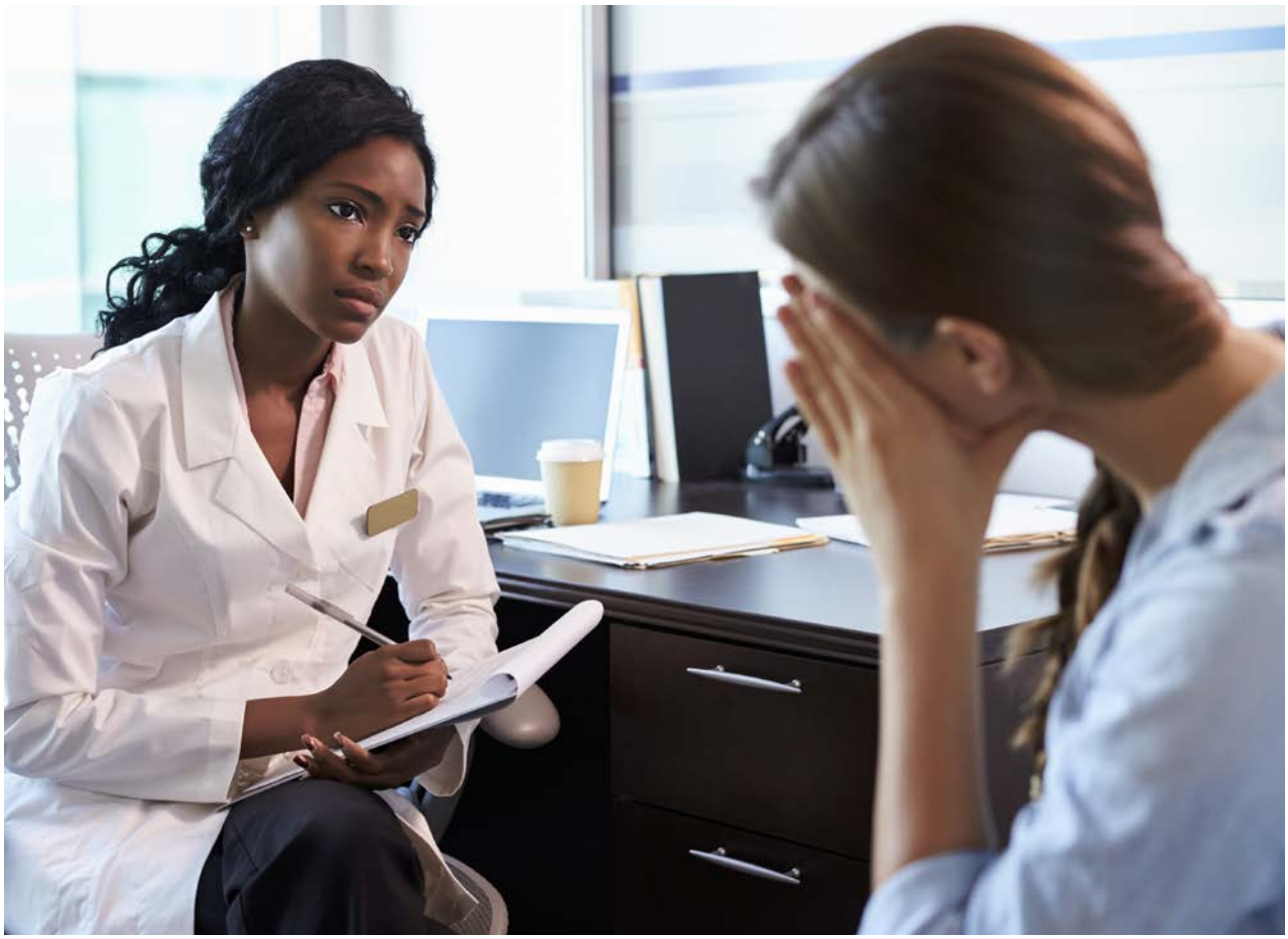
We looked at how practices handle complaints:

We explored the arrangements in place which enable patients to raise a concern in a practice. In 13 practices, we recommended that some improvements needed to be made to strengthen their arrangements in this respect. In 2015-16, we highlighted that complaints arrangements were not always satisfactory and it is therefore disappointing that we have found this to be the case once again in 2016-17. It is important that patients are fully empowered to provide feedback on the services they receive, whether this is negative or positive.

We found typical issues included the following:

- Complaints policies not in line with NHS Wales Putting Things Right procedures.
- Complaints policy and procedure not easily accessible for patients.
- Complaints policy only available in certain formats – for example, not on the website and only in the patient information leaflet.
- Improvements needed to the recording of formal and informal complaints.

Where we found that arrangements for handling complaints were good, we saw that practices had considered the need to ensure the complaints policy was widely available and accessible to as many of their patients as possible, also that the policy was up-to-date and reviewed regularly. We also noted occasions where practices were documenting and acting on complaints received informally, in addition to those formally received.



Delivery of safe and effective care

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

We found that practices were working hard to provide safe and effective care to their patients, against a challenging climate of significant demand for GP appointments at a time when recruiting sufficient numbers of GPs can be difficult.

We made a number of recommendations for improvement and these should be acted on by health boards and services that we have not yet visited, to ensure that these are not problems replicated elsewhere.

Safe Care

General Health and Safety:

During each inspection, inspectors undertook a tour of the practice building. We generally found that areas occupied by patients were clean, tidy and uncluttered. Overall, practice buildings appeared to be suitably maintained, both internally and externally. Practices had a variety of arrangements in place to protect the health and safety of staff, patients and others who might visit the premises. This was usually an area that practice staff themselves took responsibility for, but we did see some practices where they had contracted external agencies to advise on health and safety matters. In 12 practices, we made recommendations for improvements to aspects of their health and safety arrangements. Issues we identified included:

- Wooden examination couches that we were not assured were suitable for use.
- No regular (or recent) fire training for staff.
- Mixing the storage of clean and dirty materials (e.g. cleaning equipment stored in the same cupboard as unused clinical supplies).
- No system in place to manage substances under the Control of Substances Hazardous to Health Regulations (COSHH).

All practices should ensure they are fully aware of their responsibilities under health and safety legislation and take suitable steps to comply with this.

We checked to see that practices had business continuity plans in place and that these had considered what needed to happen in the event of a disaster or health emergency. We were satisfied that practices had considered their obligations in this regard.

We found that practice environments varied considerably; some had been purpose built, some were in converted buildings. As a result, there were many which would benefit from further adjustment to make them more easily accessible to patients with mobility difficulties or with pushchairs. Many practices did not have automatic entrance doors meaning that patients needed help to enter the practice. Again, this was an area HIW highlighted in 2015-16.

We found that in general, practices did not have a plan in place for addressing the need to make their premises more easily accessible. Inside, some practice premises were difficult to navigate around for those with mobility difficulties. We saw some small, cramped waiting areas where there was little room for patients to wait, particularly if they had pushchairs or were wheelchair users. Practices should consider how people with mobility difficulties can easily access and use their premises.

We looked at infection control:

Practices were all visibly clean and there were hand washing and drying facilities available in toilets and clinical areas. We also saw that hand sanitising gel was available at various points throughout practices to help with hand hygiene.

Staff had plentiful access to personal protective equipment (such as gloves and aprons) to help minimise the possibility of cross infection during treatments and procedures. The majority of practices used single use, disposable instruments and clinical equipment and there were arrangements for appropriate cleaning and decontamination if reusable equipment was in use.

Generally, there were up-to-date, practice specific infection control policies in place to guide the staff in their work. Practices were ensuring that waste was segregated correctly and stored safely prior to collection by specialist waste collection companies.

We checked to see that relevant staff involved in clinical procedures were correctly immunised against Hepatitis B and were able to confirm that there was a good understanding of this and that practices were maintaining records of staff immunisation status, which were appropriate.

We looked at how practices handle medication:

Many practices had access to a pharmacist for advice and support the extent of their involvement differed across different areas but all practices who could access a pharmacist confirmed that they found this a useful resource.

There were a range of options in place for patients to order repeat prescriptions, including on-line requests, over the telephone and in person. In one practice, we saw that two staff members had been trained to National Vocational Training Level 3 and took responsibility for issuing repeat prescriptions. There was still appropriate GP involvement in this system, but it did release some GP time for dealing with more urgent issues and we felt this represented noteworthy practice. Many practices followed advice and support from their respective health board in relation to their management of medication.

We found there were systems in place to ensure that medication reviews for patients took place, sometimes with the support of a pharmacist, sometimes by the practice GPs.

We looked at arrangements for safeguarding children and adults at risk:

All practices had arrangements in place for the safeguarding of children and adults who are vulnerable or become vulnerable or at risk. In general, practices had assigned a GP to take the lead in safeguarding. The extent to which we considered the overall safeguarding arrangements to be satisfactory was variable and in 12 out of 27 practices we made recommendations for strengthening their approach. Issues we found included:

- Not all members of the practice team had received safeguarding training.
- Staff in one practice had only received training in child protection but never in adult protection.
- Safeguarding training was not always at a level appropriate to the staff member's role.
- Communication systems being used to flag up children at risk but not adults who are vulnerable or at risk.

Where arrangements were good, we found that practices had up–to-date training and at the appropriate level for all staff members. Effective use of electronic records systems meant that staff were alerted to safeguarding concerns. There were also robust policies in place which all staff were aware of and as a result were able to understood the role they would need to play in any safeguarding cases.

Effective Care

We looked at arrangements for practices to learn from significant events:

All practices had some arrangement in place for reviewing significant events and making changes according to the learning arising from these. In a few cases, we made recommendations for improvement because the systems were not robust enough. Typically, we recommended that a better system be put in place for disseminating the learning from adverse events to all staff. We also recommended that significant events are recorded promptly and that a system for regular review is put into place.

We looked at communication arrangements at the practice:

All practices we visited had procedures in place to process communication and correspondence about patients which arrived each day. During the course of a day, the electronic systems were frequently used to enable staff to pass on important messages and updates and were also used to assign tasks to staff members ensuring that necessary actions were taken.

We saw that incoming mail and test results were usually processed on the day they were received, to help ensure that patient records are as up-to-date as possible. Arrangements were in place in almost all practices we visited for the practice to share information with the out of hours service with the aim of providing patients with continuity of care.

We looked at record keeping:

We looked at a sample of patient records in each of the practices we visited. We found many examples of good record keeping standards, with clinical entries clearly providing a diagnosis, history and treatment plan which would help to ensure continuity of patient care and ease for any other clinicians involved with that patient.

We also found examples where record keeping standards needed to improve. We made recommendations for improvements in record keeping at 11 out of 27 practices visited. The types of issues we found included:

- A lack of detail recorded. This means that continuity of care for a patient would be more difficult.
- A delay in recording home visits onto patient notes, meaning that the history of their care was not accurate.
- The person entering the record onto the system not always being identifiable from the initials used. We were told that this was an issue with the clinical system in use but it is one that needs to be rectified so that records are accurate.

We also identified that practices were struggling to accommodate the administrative burden that can exist when new patients join their practice; old notes from the previous practice are required to be summarised and incorporated into the new notes. However, we found that there was often a significant delay (due to a backlog) in this being done and therefore patient records were not as up-to-date as they should be. On occasion, practices had considered the risk associated with this and had put a system in place to mitigate the potential risk. For example, one practice we saw had a system for undertaking a medical check on each new patient during which a health questionnaire would be completed. If anything notable was identified during this, the patient's record would become high priority for early summarisation. However, in other practices, there had been no consideration given to the risks that not summarising records could present. On one occasion, the backlog of notes awaiting summary was so significant that we raised this under our immediate assurance process in order that the risk be promptly addressed.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care.

Whilst we saw teams with strong leadership who were well established and had worked together for a number of years, we also made a number of recommendations for improvements in this area in order to strengthen communication, record keeping and recruitment.

Governance, leadership and accountability

We encountered many well established staff teams with strong leadership from senior GPs and practice manager's. Staff were clear about their roles and knew what was expected of them. Lines of accountability were clear and respected.

In many practices, we found that they could make improvements to how they managed their policies and procedures (the documents themselves). We often found that these needed updating, or that there were a number of different versions but the latest one not clear. As these are key documents which should be used to guide staff in their duties, it is important that practices ensure they are maintained accurately and carefully, making it clear which is the latest version and making them easily available to all staff.

We found that whilst there was often good communication within practices, including regular staff meetings, there were occasions when these were not recorded. This meant that evidence of what was discussed was not captured and that it was not as easy to share this information with other staff members who were not in attendance. It is important that all staff meetings, particularly where decisions are made and processes changed, are properly and promptly documented so that there are clear audit trails and decisions can be accounted for and easily shared amongst staff.

We heard from practices about their involvement with GP clusters[4]; the way in which each cluster worked differed across all areas. In general, practice administration staff had less awareness of the functions and benefits of cluster working and whilst they were often aware of certain initiatives, such as a pharmacist or physiotherapist provided by the cluster, they generally did not have any other detail. Another cluster initiative that we saw in practice was the availability of additional warfarin testing equipment, meaning that patients could receive more of their care in the community.

[4] GP Clusters are a grouping of GPs working with other health and care professional to plan and provide services locally for patients. There are 64 cluster networks across Wales. www.gpone.wales.nhs.uk/clusters

Staff and Resources

Staff were generally very positive about their roles and enjoyed working in general practice. In many practices, there was very low turnover of staff and therefore teams and individuals had worked together for a number of years. Due to the infrequent need to recruit new staff, we found on two occasions that the recruitment process was not as robust as it should have been, with a lack of pre-employment checks in place. These are important as they help to ensure suitability of staff for work in this environment.

We also noted on one occasion that whilst there was an induction process in place for administration staff, there was no similar process to induct new clinical staff (healthcare assistants, nurses and GPs) to the practice. It is important that all staff are able to receive an induction relevant to their role so that they have an understanding of emergency procedures and key policies and procedures at the point of starting work.

Staff confirmed that they felt well supported to access training and that this was provided regularly through protected learning time and supported by health boards. We found that many practices could improve their records of staff training, so that any gaps in training and knowledge amongst the team can be easily identified and this information can be used in conversations with health boards about future training requirements.

The majority of practices were conducting annual staff appraisals but we did find some examples where these were not taking place and for some, it had been a number of years since they had received an appraisal. Appraisals are another important mechanism by which staff can communicate with management and through which training needs can be identified and addressed.

5. Conclusions

2016-17 was the third year of HIW inspections of general practices. Again we found that practices were generally keen to engage with the inspection process, recognising the opportunity inspection provides for objective and constructive feedback on their service provision.

Our overall findings from the year were positive; patients were very complimentary about the care they received from their GP practice. Practice teams were committed to providing high quality services to their patients. We did see that GP practices often struggle to cope with demand for appointments and that the design of some of the appointment making systems made it difficult for patients to easily access appointments when needed.

Practices had arrangements in place to support the delivery of safe and effective care. Some practices needed to improve their provision of bilingual (Welsh/English) information and we also found that at times there needed to be improvements to aspects of general health and safety management.

Management and leadership were generally satisfactory and we saw many example of strong leadership from GPs and practice managers. Many practices would benefit from a more formal approach to the development and maintenance of policies and procedures so that staff can be more easily guided in their work. Recruitment procedures also needed to be improved in some practices so that staff are carefully assessed for their suitability to work within the health sector.

HIW issued immediate assurance letters in two out of the 27 inspections.
The recommendations we made were acted on appropriately and we were satisfied with the responses we received.

We have made a number of overarching recommendations for improvement which can be found in Appendix A of this report. Many of our overarching recommendations are similar to those made in 2015-16 (and previous years in some cases). It is therefore important that health boards do not miss the opportunity to share the learning and messages provided by this report to support practices within their area to avoid the common issues and shortfalls in service provision identified by these inspections.

6. What next

- HIW will continue its programme of GP practice inspections in 2017/18.
- HIW will continue to place the patient experience at the heart of what it does and will always seek the patient views during inspection visits.
- HIW will continue to publish GP inspection reports on its website, being open and honest in the way it reports.
- HIW will continue to use the expertise and professionalism of GP and practice manager peer reviewers at future inspections.
- HIW will continue to work with its stakeholder reference group (established in 2014) to obtain the views of a range of stakeholders who challenge and support HIW's GP inspection programme. This helps to ensure that HIW's GP inspections remain credible, relevant, proportionate and effective.

Appendix A

Recommendations

As a result of the findings from our 27 inspections in 2016-2017, we have made the following overarching recommendations which all services should consider as part of providing a safe and effective service.

Whilst we have seen some areas of improvement in services inspected in 2016-2017, it is disappointing that the majority of recommendations are reflective of those made in 2015-2016.

Patient Experience	
Recommendations	**Regulation/Standard**
Practices must ensure that they have taken all possible steps to maintain patient privacy and confidentiality at reception areas.	Health and Care Standard 4.1
Chaperone arrangements need to be consistently advertised to patients. Staff acting as chaperones must also be appropriately trained so that they fully understand the purpose and implications of what they are doing.	Health and Care Standard 4.1
Practices need to ensure they have considered their obligations under the Health and Care Standards in relation to meeting the Welsh language needs of patients. It is important to ensure that bilingual (Welsh/English) information is made available without the need for patients to ask for it. Information in other languages should also be considered as appropriate.	Health and Care Standards 3.1 and 3.2
Practices must ensure that the design of their appointment making system is accessible to all patients, including those with additional needs.	Health and Care Standard 4.2
Practices should ensure they have a regular means of seeking patient feedback in a proactive manner.	Health and Care Standard 6.3
Complaint policies should be kept up to date and in line with NHS Putting Things Right procedures. They must also be made easily accessible to all patients.	Health and Care Standard 6.3

Delivery of Safe and Effective Care	
Recommendations	**Regulation/Standard**
Practices should ensure they are aware of and fulfilling their responsibilities under Health and Safety law.	Health and Care Standard 2.1
Practices should review the ease of access into and around the inside of their premises, ensuring that they develop a plan of action to address any issues they identify.	Health and Care Standard 2.1
Safeguarding training (both adults and children) should be a priority and ensuring that all staff are trained, to the appropriate level is something practices must ensure.	Health and Care Standard 2.7
Patient records must contain sufficient detail to enable continuity of care. Home visits must be promptly recorded.	Health and Care Standard 3.5
Practices must ensure that there is a suitable system for managing new patients registering so that their medical needs and relevant past medical history are documented in their notes without delay.	Health and Care Standard 3.5
Quality of Management and Leadership	
Recommendations	**Regulation/Standard**
Policies and procedures must be updated regularly and the most recent version should be clearly marked.	Health and Care Standard 3.1
Staff meetings should be recorded.	Health and Care Standard 3.4
Recruitment processes must be robust enough to sufficiently assess the suitability of staff prior to appointment.	Health and Care Standard 7.1
Annual appraisals should be undertaken and documented for all staff.	Health and Care Standard 7.1