Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

# General Practice Inspection (announced)

## Aneurin Bevan University Health Board,
## South Street Surgery

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## 1. Introduction

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of all health care in Wales.

HIW's primary focus is on:

- Making a contribution to improving the safety and quality of healthcare services in Wales
- Improving citizens' experience of healthcare in Wales whether as a patient, service user, carer, relative or employee
- Strengthening the voice of patients and the public in the way health services are reviewed
- Ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.

HIW completed an inspection at South Street Surgery, South Street, Bargoed, Mid Glamorgan, CF81 8SU on 19 October 2016. Our team for the inspection comprised of an HIW inspection manager (inspection lead), a GP peer reviewer, a practice manager peer reviewer and two representatives from Aneurin Bevan Community Health Council.

HIW explored how South Street Surgery met the standards of care set out in the Health and Care Standards (April 2015).

Inspections of General Medical Practice (GP) are announced and we consider and review the following areas:

- Quality of the patient experience - We speak to patients (adults and children), their relatives, representatives and/or advocates to ensure that the patients' perspective is at the centre of our approach to how we inspect
- Delivery of safe and effective care - We consider the extent to which, services provide high quality, safe and reliable care centred on the person
- Quality of management and leadership - We consider how services are managed and led and whether the culture is conducive to providing safe and effective care. We also consider how services review and monitor their own performance against relevant standards and guidance.

## 2. Context

South Street Surgery currently provides services to approximately 2,500 patients in the Bargoed area of Caerphilly. There is a branch surgery at Cefn Fforest Surgery, Bryn Road, Blackwood, NP12 3NA. The practice forms part of GP services provided within the geographical area known as Aneurin Bevan University Health Board.

The practice employs a staff team which includes one doctor, one locum doctor, one nurse, one practice manager, one assistant practice manager, one phlebotomist/receptionist and one receptionist.

The practice provides a range of services (as cited in the patient information leaflet), including:

- Antenatal clinic
- Child surveillance, vaccination and immunisation
- Hypertension clinic
- Asthma clinic
- Diabetes clinic
- Coronary heart disease clinic
- Smear clinic
- Chronic Obstructive Airways Disease clinic
- Flu clinic
- Counselling service
- Smoking cessation service

## 3. Summary

HIW explored how South Street Surgery met standards of care as set out in the Health and Care Standards (April 2015).

Overall, we found evidence that South Street Surgery provides safe and effective care. However, improvements were required to ensure there were robust and formalised arrangements in place to support safe and effective care.

This is what we found the practice did well:

- Patients were happy with the service provided
- Staff knew patients well and there was good continuity of care
- There was a wide range of patient information available
- Staff we spoke with were happy in their roles and felt well supported
- Patient records were of a good standard.

This is what we recommend the practice could improve:

- Staff's awareness and the practice's compliance with health and safety policy
- Review and formalisation of some aspects of internal communication systems
- Staff required training in child and adult protection and related policies require further detail
- A formalised recruitment procedure must be put in place
- A number of policies and procedures require review, further detail and improved organisation to ensure they are up to date and able to effectively support staff in their roles and responsibilities.

## 4. Findings

### *Quality of patient experience*

**Members of the local Community Health Council (CHC) spoke with patients and used questionnaires to obtain patients' views. CHC questionnaires were completed by patients both prior to and during the inspection. 95 questionnaires were completed in total. Overall, patient satisfaction was very high and patients gave overwhelmingly positive feedback about access to appointments and their relationships with staff delivering services.**

**Staff knew patients and their family/carers well and we found people were treated with dignity and respect by staff. We have asked the practice to ensure that non clinical staff acting as chaperones are provided with training. The practice had a system in place to enable patients to raise concerns/complaints and to provide feedback on services.**

The CHC have produced a report which provides an analysis of the information gathered. That report can be found in Appendix B. Overall, patient satisfaction was very high. Patients made positive comments particularly about the friendliness of staff and efficiency of the service.

We suggested the practice consider providing a range of seating to ensure patients (who may have difficulties with mobility and transfers) are as comfortable as possible when waiting to be seen. Other comments made by patients included a request for more specialist information on heart failure and for weekend appointments.

*People's experience of health care is one where everyone is treated with dignity, respect, compassion and kindness and which recognises and addresses individual physical psychological, social, cultural, language and spiritual needs. (Standard 4.1-Dignified Care)*

We found that people were treated with dignity and respect by staff.

We observed staff greeting patients both in person and by telephone in a polite, friendly and welcoming manner and treating them with dignity and respect. It was clear that staff knew patients and their families extremely well and they placed an emphasis on meeting patients' individual needs with respect and kindness.

The reception area was enclosed with staff separated from patients by clear windows. This gave privacy to staff taking telephone calls and discussing patients' needs. Staff also told us that they could use private rooms to discuss any sensitive issues with patients to maintain confidentiality. There were small discreet areas in the waiting area where patients could wait with a greater degree of privacy, if they wished.

In the records we reviewed we saw that GPs had documented patients' consent to examinations and had used consent forms where needed and appropriate. The website also provided good clear information about confidentiality and the use of medical records.

We saw that doors to individual consultation and treatment rooms were kept closed at all times when staff were attending to patients. This meant staff were taking appropriate steps to maintain patients' privacy and dignity during consultations.

Staff told us that, normally, the nurse or practice manager acted as formal chaperones. This meant that, at times, non clinical staff were used in this capacity. There was not currently any training provided for acting as a chaperone, even though the practice's chaperone policy stated that staff should receive training to act in this role. We advised the practice to ensure non clinical staff were made aware of, and trained for, the requirements and responsibilities this role entailed.

***Improvement needed***

***The practice should ensure that non clinical staff acting as formal chaperones are made aware of the requirements and responsibilities this role entails and have access to up to date guidance on acting in this role.***

*People who receive care, and their families, must be empowered to describe their experiences to those who provided their care so there is a clear understanding of what is working well and what is nor, and they must receive and open and honest response. Health Services should be shaped by and meet the needs of the people served and demonstrate that they act on and learn from feedback. (Standard 6.3-Listening and Learning from Feedback)*

There was a complaints process in place and a system to empower patients and their families/carers to provide feedback on their experiences of using the practice.

The practice had a written procedure in place for patients to raise concerns and complaints. Complaints information was displayed in an easily visible place on

a noticeboard in the waiting area and leaflets were also available. There was also information on the website. This meant patients could easily access this information from the practice should they require it. The written procedure provided basic information and we were not able to assess whether it had been recently reviewed. However, it was fully compliant with ‘Putting Things Right’ requirements, the current arrangements for dealing with concerns (complaints) about NHS care and treatment in Wales. This included information about how to access CHC as an advocacy service with making complaints, and we saw CHC information visibly displayed in waiting areas.

We saw that staff maintained records of complaints. There had been no recent complaints.

The practice gathered patient feedback through an annual patient questionnaire and by using CHC questionnaires. We also saw that staff had recently implemented a system to record any verbal feedback provided by patients. The practice should consider how to encourage and empower patients to provide feedback in this way on an ongoing basis.

Staff told us that no patients had come forward to show interest in a patient participation group so they had not pursued this as a further means to provide feedback on services.

## *Delivery of safe and effective care*

**We found a staff team who were patient centred and committed to delivering a high quality service to their patients, whom they knew well and whom received good continuity of care. However, improvements were required to ensure there were robust and formalised arrangements in place to promote safe and effective patient care.**

**Information was available to patients to help them take responsibility for their own health and well being and to signpost carers to help and support available to them. There was a full and detailed practice leaflet available for patients.**

**Suitable arrangements were in place to ensure the safe prescribing and review of medicines and to learn from any patient safety incidents. The sample of patient records we reviewed were of a good standard.**

**Improvements are needed to ensure the practice adheres to health and safety policy and to ensure that full risk assessments are undertaken. The practice must be able to demonstrate that they have assessed and taken action to minimise any risks within the environment, fire risks, infection control and actions in the event of an emergency.**

**Internal communication systems were in place but require review and formalising to ensure that they fully supported effective patient care.**

**The child protection policy and protection of vulnerable adults policy requires further detail and staff had not completed up to date training in these areas.**

### Staying healthy

*People are empowered and supported to take responsibility for their own health and wellbeing and carers of individuals who are unable to manage their own health and wellbeing are supported. Health services work in partnership with others to protect and improve the health and wellbeing of people and reduce health inequalities. (Standard 1.1)*

There was an excellent range of information available to help patients to take responsibility for their own health and well being. There was information to support and signpost carers to help and support available to them.

We saw a variety of health promotional materials on display in waiting areas which were easily accessible to patients. The practice also ran a ‘Living Well’

service which was proactive in promoting health checks and a smoking cessation clinic to support patients around these health improvements.

There was information available for carers on noticeboards in the waiting area, the practice maintained a carer's register and the practice manager acted as the carer's champion to promote knowledge around carers' needs.

## Safe care

*People's health, safety and welfare are actively promoted and protected. Risks are identified, monitored and where possible, reduced or prevented. (Standard 2.1-Managing Risk and Promoting Health and Safety)*

During a tour of the practice building we found that all areas occupied by patients were clean, tidy and uncluttered which reduced the risk of trips and falls. Overall the practice building was suitably maintained, both internally and externally.

There was no health and safety policy in place giving guidance to staff on health and safety requirements for the practice as a whole. Other policies covered aspects of health and safety such as waste management. However, overall, policies had basic details and require full review and updating. The policies available did not cover all health and safety requirements such as display screen equipment, fire safety and manual handling. We advised staff to consult the Health and Safety Executive to ensure they comply with all relevant health and safety requirements.

***Improvement needed***

***The practice must ensure there is a full, localised, up to date health and safety policy in place that covers all mandatory areas.***

Staff told us that since one staff member (who had held responsibility for health and safety), had left some years ago, there had been a lack of attention in this area. This meant that staff had not received any training during the past twelve months with regard to health and safety legislation.

***Improvement needed***

***The practice is required to inform HIW of the action taken to ensure that all staff receive training with regard to health and safety legislation.***

We found that there was a display screen equipment policy held at the practice. However, when asked, staff had never been offered a formal risk assessment

of their office work station/desk area or support as to how to complete an individual assessment; being frequent computer users.

***Improvement needed***

***The practice is required to inform HIW of the action taken to ensure that the health, welfare and safety of staff (who are frequent users of computers in the workplace), has been assessed, in accordance with existing health and safety legislation.***

There was no system in place in regards to the Control of Substances Hazardous to Health (COSHH). Legally, employers are required to control exposure to hazardous substances to prevent ill health by complying with the Control of Substances Hazardous to Health Regulations 2002 (COSHH). The practice manager agreed to attend to this as soon as possible.

***Improvement needed***

***The practice must ensure that they comply with Control of Substances Hazardous to Health Regulations 2002 (COSHH).***

Although we did not see any risks of immediate concern, we were not assured that risks had been fully assessed or actions taken to minimise them. Staff had not completed an environmental risk assessment since 2010, or a fire risk assessment since 2012, and no recent fire training had taken place. There was a fire emergency action plan in place that had been completed within the last two years. There is a legal duty to assess the risks to the health and safety of employees (and risks to the health and safety of persons visiting the premises). The practice manager agreed to resolve this as soon as possible.

***Improvement needed***

***The practice must ensure that they carry out environmental risk assessments and fire risk assessments to identify and manage any risks within the practice environment.***

The practice manager talked us through their business risks and contingency plans. The practice was buddied with a neighbouring practice and staff told us they worked in partnership to provide support in emergencies. However, this arrangement appeared informal and we could not be assured that there were formal agreements in place to manage emergencies. There was a plan for managing significant health emergencies but this requires updating to ensure it is still relevant.

***Improvement needed***

***The practice must ensure that there are formalised emergency arrangements in place in regards to contingency planning and managing significant health emergencies.***

*Effective infection prevention and control needs to be everybody's business and must be part of everyday healthcare practice and based on the best available evidence so that people are protected from preventable healthcare associated infections. (Standard 2.4-Infection Prevention and Control (IPC) and Decontamination)*

Staff confirmed they had access to personal protective equipment such as gloves and disposable plastic aprons to reduce cross infection. The clinical treatment areas we saw were visibly clean. Hand washing and drying facilities were provided in clinical areas and toilet facilities. Hand sanitisers were also readily available around the practice. We saw that waste had been segregated into different coloured bags/containers to ensure it was stored and disposed of correctly. Clinical waste was securely stored until it could be safely collected.

Discussion with nursing staff confirmed that all instruments used during minor surgery procedures were purchased as sterile, single use packs. This avoided the need for the use of sterilisation/decontamination equipment.

There were two different infection control policies in place and we could not be assured that all staff were aware of which policy was currently in use. One was detailed and generic and the other policy had a lack of overall detail. There is a need to review the policy, update it, provide practice specific detail and ensure all staff are aware of their responsibilities in regards to the policy.

***Improvement needed***

***The practice must ensure that there is a clear infection control policy in place, that all staff are aware of their responsibilities in regards to the policy and that the policy is readily available to all staff.***

Staff told us they had not carried out any assessment or audit to asses or monitor the environment for infection control risks. Although we did not see any immediately identifiable infection control risks, the practice must ensure that they are able to demonstrate compliance with infection control procedures.

***Improvement needed***

***The practice must ensure there are systems in place to monitor infection control standards and take action to comply with infection control guidelines.***

Conversations with senior members of the staff team highlighted that all clinical staff were expected to ensure they received Hepatitis B vaccinations as required. However, there was no system in place to retain evidence of vaccination or immunity records within individual staff files. This meant that we could not be assured, at the time of inspection, that the practice had taken appropriate steps to protect patients and individuals working at the practice.

***Improvement needed***

***The practice is required to provide HIW with evidence of Hepatitis B vaccination and subsequent immunity records for all members of the clinical team.***

*People receive the right medicines for the correct reason, the right medication at the right dose and at the right time. (Standard 2.6)*

We found that suitable arrangements were in place for the safe prescribing of medicines to patients.

Patients could access repeat prescriptions by calling into the surgery in person. The practice used the health board's formulary[1].

Medication reviews took place in a number of ways, either opportunistically when patients attended appointments, via chronic disease clinics, or, in cases where patients took six medications or more, through running off a list and organising specific mediations reviews for these patients.

Arrangements were in place to remove medication no longer needed by patients from repeat prescribing lists.

There was a pharmacist who worked across their Neighbourhood Care Network (NCN)[2] and gave support to the practice. The support involved scrutiny of

[1] The formulary lists all medicines approved for use in primary and secondary care in Aneurin Bevan University Health Board

repeat prescribing and prescribing of medicines for chronic disease. Staff told us they also undertook audits through their NCN.

We saw from the patient records that there were some cases where Type 2 diabetic patients were not currently prescribed statins[3] and the reasons for this were not always recorded in patient records. The practice needs to ensure that when individual prescribing practice falls outside recommended guidelines the reasons for the action are clearly recorded, e.g. statin prescribing in Type 2 diabetes. We have therefore asked that the practice review all Type 2 diabetic patients to ensure consistent prescribing and sufficient detail in records.

***Improvement needed***

***The practice should review all Type 2 diabetic patients to ensure that there is consistent prescribing of statins and that sufficient detail is kept where individual prescribing practice falls outside recommended guidelines.***

*Health services promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time. (Standard 2.7- Safeguarding Children and Safeguarding Adults at Risk)*

There was a designated lead for child protection. There was a child protection policy in place but this did not provide sufficient detail clarifying what abuse is, the different types of abuse or staff roles and responsibilities in reporting abuse. There was a flowchart which included local contact numbers for reporting. We advised staff to amend the policy to comply with All Wales legislation and guidance, so that it guides staff in identifying and managing all child protection matters.

There was a policy in place around the protection of vulnerable adults (POVA) but this also lacked detail and local contact numbers for reporting any matters

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[2] **Neighbourhood Care Network** is the term used for practice clusters within Aneurin Bevan University Health Board. A practice cluster is a grouping of GPs and Practices locally determined by an individual NHS Wales Local Health Board. Neighbourhood Care Networks were first established in 2010. They bring together GP practices, District Nursing, Frailty, Public Health Wales, Primary and community mental health services and the voluntary sector.

[3] **Statins** are cholesterol lowering drugs

of concern. We advised staff to amend the policy to comply with All Wales legislation and guidance, so that it guides staff in identifying and managing all POVA matters.

***Improvement needed***

***The child protection and POVA policies require review and updating to ensure they include sufficient detail, local referral numbers and that they comply with All Wales legislation and guidance.***

Staff had last undertaken child protection training 10 years ago and staff had not completed training in adult protection. We could therefore not be assured that staff were sufficiently trained to identify and manage issues of child and adult protection.

***Improvement needed***

***The practice must ensure that all staff are up to date with child protection and vulnerable adults training at a level appropriate to their role.***

Staff flagged child and adult protection cases on the electronic system so that staff were alerted to these cases. There were registers in place recording those patients who were vulnerable, such as patients with mental health needs, learning disabilities and carers. A social worker was due to start imminently to provide support to practices across the NCN.

## Effective care

*Care, treatment and decision making should reflect best practice based on evidence to ensure that people receive the right care and support to meet their individual needs. (Standard 3.1-Safe and Clinically Effective Care)*

The practice had suitable arrangements in place to report and learn from patient safety incidents and significant events.

Senior staff at the practice explained that patient safety incidents and significant events were reviewed and discussed on an adhoc basis when the need arose. We looked at records and confirmed that reviews of incidents and events took place with relevant members of the practice team coming together when needed and actions being passed onto staff.

We saw that one significant event had been recorded three months ago, but notes on this not yet typed up. We advised staff to try to ensure this was done as soon as possible, so that staff remember full details and can ensure full, accurate, formalised recording in a timely way.

We saw that staff reviewed significant events annually, informally monitoring for themes and trends between these times. The practice team could consider formalising the arrangements in place, arranging regular scheduled meetings to review all events, concerns and patient feedback as a whole, to assist with monitoring and making ongoing overall improvements to services.

*In communicating with people health services proactively meet individual language and communication needs. (Standard 3.2-Communicating Effectively)*

Staff told us that they would produce information for patients in different formats on request and could use interpreting services when needed.

The practice had systems for the management of external and internal communications, however, these required formalisation in some cases. We saw that staff had an arrangement whereby they scanned all correspondence coming into the practice onto the system during the quieter afternoon periods. However, staff told us they did not always manage to scan all correspondence every day and there was no formal policy in place which specified timescales in passing on correspondence. We also heard that, at times, the doctors took correspondence from the pile in order to action in a more timely way. This meant that some stages of the process could be missed in ensuring patient records were fully up to date.

***Improvement needed***

***The practice must ensure that there is a formalised process in place, understood and adhered to by all staff, in managing correspondence coming into the practice and to ensure this happens in a consistent and timely manner.***

Staff told us that they received discharge summaries from secondary care electronically within Aneurin Bevan University Health Board and in a timely way which helped to ensure they had up to date information about patients. However, there were sometimes challenges when receiving discharge summaries from other health boards, particularly those patients discharged from Prince Charles Hospital. Staff told us that these summaries were sometimes of poor quality. This was being taken forward by the NCN. There was a system in place for ensuring discharge summaries were passed onto the doctor in a timely way.

We saw that there was a message book in place which staff used to pass on messages between themselves, for example, when there may be a request for a patient to be telephoned. However, on examination we found that this was not

regularly used and when it was, messages were not consistently signed to say that staff had read the message and taken action. This meant that messages tended to be passed between staff members in a more informal way. We advised the practice that there should be a system in place to demonstrate an audit trail and accountability in actioning messages.

***Improvement needed***

***Staff should ensure that there is a clear internal process in place which demonstrates accountability in passing on and actioning messages.***

Some of the internal communications systems in place meant that there was duplication of work with time being spent both scanning documents and also filing them in paper records. Staff told us they were moving to an electronic system but did not yet feel sufficiently assured of the electronic system to rely on this wholly, and so also kept paper copies of all documents. We advised staff to review internal communication systems to consider how they could be streamlined and formalised to support effective patient care and best use of staff time.

***Improvement needed***

***The practice should review all internal communications systems to consider whether improvements could be made and to ensure there is sufficient formalisation and accountability built into systems.***

*Good record keeping is essential to ensure that people receive effective and safe care. Health services must ensure that all records are maintained in accordance with legislation and clinical standards guidance. (Standard 3.5-Record Keeping)*

We looked at a random sample of electronic patient records for each member of clinical staff working at the practice and overall found a very good standard of record keeping.

Notes contained sufficient detail of consultations between clinical staff and patients and it was possible to determine the outcome of consultations and the plan of care for the patient.

**Dignified care**

*People must receive full information about their care which is accessible, understandable and in a language and manner sensitive to their needs to*

*enable and support them to make an informed decision about their care as an equal partner (Standard 4.2- Patient Information)*

Information for patients about the practice's services was available within a practice leaflet. This was comprehensive and provided useful information, including details of the practice team, opening hours, the appointment system, the procedure for obtaining repeat prescriptions and how patients could make a complaint. There was also comprehensive information available on the practice's website. We saw that the practice website contained an incorrect telephone number for the out of hours service and the practice manager rectified this immediately

We were told the practice leaflet would be produced in other formats and languages on request. We advised the practice to make information available in Welsh and other formats according to the needs of the practice population. The practice should consider how to make their practice leaflet as accessible as possible to those patients who speak different languages or those patients requiring large print or other accessible formats, in a proactive way.

The practice had a hearing loop which they used to aid communication with those patients with hearing difficulties.

A range of information was displayed and readily available within the waiting area of the practice. This included information on local support groups, health promotion advice and self care management of health related conditions.

Due to the small size of the practice and staff team, many of whom had worked at the practice for 20+ years there was good continuity in patient's care and treatment.

**Timely care**

*All aspects of care are provided in a timely way ensuring that people are treated and cared for in the right time, in the right place and with the right staff. (Standard 5.1-Timely Access)*

Patients were able to book appointments in person at the practice, by telephone and online. There was a text reminder service in place. Patients could book urgent appointments on the same day and routine appointments were available within 48hours. Staff told us that they would always try to accommodate anyone who had an urgent need for an appointment on the same day. We observed one patient calling in for a flu jab without an appointment and the nurse was able to fit them in immediately. Patients provided positive feedback in questionnaires around access to appointments.

Although the branch surgery wasn't normally used for patients to access consultations, staff told us that this could be arranged if needed.

The nursing team were able to see patients presenting with minor general illnesses (described as non urgent) if needed. The nursing team also ran a number of clinics for patients with chronic health conditions so that they could access the care and treatment they needed without having to see a doctor.

Staff explained the referral process and we saw that there were procedures in place to ensure urgent referrals were acted on immediately and routine referrals processed in a systematic way. Electronic referrals could be made within Aneurin Bevan University Health Board and systems were in place to process referrals in a timely way to external health boards. There was a system in place to check that urgent referrals or urgent suspected cancer referrals had been received.

**Individual care**

*Health services embed equality and human rights across the functions and delivery of health services in line with statutory requirement recognising the diversity of the population and rights of individuals under equality, diversity and human rights legislation (Standard 6.2-Peoples Rights)*

The team knew patients well and made adjustments based on this knowledge of people's individual needs.

The practice building had been purpose built as a general practice health care facility around 26 years ago. There was a ramp and level access making it accessible to patients with mobility difficulties and those patients who used wheelchairs.

There was an electronic sign which indicated when staff were ready to see patients. Staff knew patients well and we saw reception staff calling patients into their appointments when extra prompts were needed.

Overall, arrangements were in place to protect the privacy of patients. However we saw that patients' paper records were currently stored behind reception and were not locked away. There was a door which allowed access between reception and the waiting area which could be locked, although we noticed that this tended to remain unlocked and open for ease of access. The door was a 'stable door' design and the top part usually remained open. This meant we could not be assured that there was sufficient security to prevent unauthorised access to patient records in this area.

***Improvement needed***

***The practice must ensure that patient's paper records are stored in line with national legislation requirements. Specifically, that patient records currently stored behind reception, are securely stored.***

## *Quality of management and leadership*

**The practice had a clear management structure in place. We found a patient-centred staff team who told us they were well supported.**

**Improvements are needed to ensure there is a formalised recruitment procedure in place, that all policies and procedures are brought up to date and that there is sufficient management time in order to oversee ongoing training requirements and overall system improvements, review and development.**

**Governance, leadership and accountability**

*Effective governance, leadership, and accountability in-keeping with the size and complexity of the health service are essential for the sustainable delivery of safe, effective person-centred care.*

Overall, we found a stable, patient-centred staff team and staff were positive about the working environment. The practice manager told us that they would like to improve delegation within the practice to help in ensuring various aspects of the work is owned by everyone and to ensure areas are up to date. We saw that the practice manager also took on reception duties alongside their practice management role and this meant there was less dedicated time to focus on system improvements, review and updating.

***Improvement needed***

***The practice must ensure that there is sufficient practice management time available to enable staff to fulfil their responsibilities.***

Staff told us they felt able to approach management to raise concerns and felt they received good support. There were two separate whistleblowing policies in place and we could not be assured that staff were clear about which one was currently in use or that all staff had been made aware of this policy.

***Improvement needed***

***Staff should clarify which whistleblowing policy is currently in place and should be able to demonstrate that all staff have been made aware of this policy.***

The practice had a range of relevant written policies and procedures to guide staff in their day to day work. However, these tended to be stored in different places, both electronically and in hard copy format and we saw that the copies

available for staff in hard copy format were older versions, in some cases. In some cases we found duplication with several versions of the same policies and staff were not always clear about which policy was currently in use. We could also not be assured that these were updated on an ongoing basis as most policies lacked review dates. We saw that most policies were limited in detail and there was a lack of evidence to show that policies had been communicated to staff or to show that staff had acknowledged that they understood them.

***Improvement needed***

***The practice should ensure that all mandatory policies and procedures are in place, contain sufficient detail and are updated on a regular basis. Policies and procedures should be communicated to staff to ensure consistency of working practices and clarity over staff's roles and responsibilities. The practice should consider improving the organisation of policies and procedures so that they are easily located and accessible when needed.***

The practice undertook mandatory audits through the health board and NCN but did not audit other aspects of the practice with a view to making improvements. We suggested that staff consider doing this as a way to evidence what was working well and what was working less well, so that action and change could be initiated.

Staff told us they met to discuss practice issues mainly in an informal way and on a daily basis, due to the small size of the practice. Practice meetings were also held on a two to three monthly basis which were minuted, although overall communication tended to be more informal. We advised the practice to keep notes of the important points of any informal meetings held between these times, to ensure a clear audit trail is in place.

The practice had a detailed and reflective Practice Development Plan which they had developed through their NCN. This clearly identified the practice's aims and we could see that progress had been made in some areas. Senior staff told us about their future plans for the practice and they were working collaboratively with another practice in this regard.

Senior staff attended the NCN meetings and used this forum as a way to generate quality improvement activities and to share good practice. The nurse also attended practice nurse meetings which involved an element of continued professional development and helped to keep them informed of practice developments and reduced isolation.

*Health services should ensure there are enough staff with the right knowledge and skills available at the right time to meet need. (Standard 7.1-Workforce))*

Staff were able to describe their roles and responsibilities and indicated they were happy in their roles. All staff we spoke with confirmed they felt supported by senior staff and had opportunities to attend relevant training. Staff told us they had annual appraisals and a sample of staff records supported this. This gave staff the opportunity to receive feedback on their performance, to discuss training needs and indicate if any additional support was needed.

Due to the stability of the staff team, the recruitment of new staff was rare. However, new staff had been recruited within the last year. We requested recruitment paperwork for staff and found that there was no formalised recruitment procedure in place. Staff told us they did not have an interviewing procedure in place, they did not routinely request references and there was no formal procedure in place to ensure appropriate checks were carried out prior to employment. We raised our concerns in this regard and advised the practice of their duties in respect of recruitment procedures.

***Improvement needed***

***The practice must ensure there is a formalised recruitment procedure in place which adheres to national legislation and guidelines. The practice must ensure that any staff now working at the practice, who were recruited without adhering to these guidelines, are suitably assessed for their fitness to undertake their roles and that all relevant checks are undertaken in order to safeguard both staff members and patients.***

Staff told us they had received a good induction to working at the practice and felt well supported when learning their roles.

Discussions with staff indicated they had the right skills and knowledge to fulfil their identified roles within the practice. However there was a lack of centrally stored information gathered in regards to staff training, skills and appropriate checks for the practice to be able to fully demonstrate this.

The practice kept some individual certificates of staff training records but did not currently assess staff's training needs both individually and as a whole on an annual basis or have a clear idea about mandatory training topics. We could therefore not be assured that the practice supported staff to stay up to date with ongoing training requirements.

***Improvement needed***

***The practice must ensure that all staff stay up to date with ongoing training requirements.***

## 5. Next steps

This inspection has resulted in the need for the GP practice to complete an improvement plan (Appendix A) to address the key findings from the inspection.

The improvement plan should clearly state when and how the findings identified at South Street Surgery will be addressed, including timescales.

The action(s) taken by the practice in response to the issues identified within the improvement plan need to be specific, measureable, achievable, realistic and timed. Overall, the plan should be detailed enough to provide HIW with sufficient assurance concerning the matters therein.

Where actions within the practice improvement plan remain outstanding and/or in progress, the practice should provide HIW with updates to confirm when these have been addressed.

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

## 6. Methodology

The new Health and Care Standards (see figure 1) are at the core of HIW's approach to inspections in the NHS in Wales. The seven themes are intended to work together. Collectively they describe how a service provides 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.

**Figure 1: Health and Care Standards**


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

- Information held to date by HIW
- Conversations with patients and interviews of staff including doctors, nurses and administrative staff
- Examination of a sample of patient medical records
- Scrutiny of policies and procedures

- Exploration of the arrangements in place with regard to clinical governance.

These inspections capture a *snapshot* of the standards of care within GP practices.

We provide an overview of our main findings to representatives of the practice at the feedback meeting held at the end of each of our inspections.

Any urgent concerns emerging from these inspections are brought to the attention of the practice and the local health board via an immediate action letter and these findings (where they apply) are detailed within Appendix A of the inspection report.

*Appendix A*

## General Medical Practice: Improvement Plan

## Practice: South Street Surgery

## Date of Inspection: 19 October 2016

| Page Number | Improvement Needed | Standard | Practice Action | Responsible Officer | Timescale |
|---|---|---|---|---|---|
| **Quality of the patient experience** | | | | | |
| 6 | The practice should ensure that non clinical staff acting as formal chaperones are made aware of the requirements and responsibilities this role entails and have access to up to date guidance on acting in this role. | 4.1 | All non clinical staff have been allocated passwords in order to access online training January 2017 for formal chaperones and made aware of the requirements and responsibilities the role entails. All staff are able to access up to date guidance on acting in this role via the training. Each member of staff was allocated a set time to access the training in a quiet environment within the surgery to complete the training. All Chaperone requests are read | Janet Hagerty | March 2017 |

| Page Number | Improvement Needed | Standard | Practice Action | Responsible Officer | Timescale |
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| | | | coded.<br>A Chaperone policy is already in place and all staff are aware of the policy. Patients are also aware that they may request a Chaperone at any time via posters in reception, verbally by staff, patient electronic information display in waiting area, internet and practice leaflet. | | |
| **Delivery of safe and effective care** | | | | | |
| 9 | The practice must ensure there is a full, localised, up to date health and safety policy in place that covers all mandatory areas. | 2.1; Health and Safety Executive | An up to date localised Health and Safety policy has been put in place which covers all mandatory areas including COSHH, Fire Safety, Risk Assessment, Waste Management, DSE risk assessment, Personal Protection Equipment, Needlestick Injuries, Accidents. This will be ongoing and staff will be routinely consulted on health and safety matters as they may arise, but also formally consulted at regular health and safety performance review | Janet Hagerty | Completed<br>January 2017 |

| Page Number | Improvement Needed | Standard | Practice Action | Responsible Officer | Timescale |
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| | | | meetings or sooner if required. | | |
| 9 | The practice is required to inform HIW of the action taken to ensure that all staff receive training with regard to health and safety legislation. | 2.1; Health and Safety Executive | Practice Manager has completed Health & Safety via online training, following this all staff have now received up to date in-house Health and Safety training including Manual Handling, Fire Safety, Security which had been set as a priority. Staff are routinely consulted on health and safety matters as they arise and also formally consulted at regular health and safety performance review meetings or sooner if required. An Accident Book is kept in reception area which all staff are aware of. | Janet Hagerty | February 2017 |
| 10 | The practice is required to inform HIW of the action taken to ensure that the health, welfare and safety of staff (who are frequent users of computers in the workplace), has been assessed, in accordance with existing health and safety legislation. | 2.1; Health and Safety Executive | A DES Workstation Risk Assessment Checklist has been completed for all members of staff in accordance with existing health and safety legislation. Health Surveillance Questionnaires have been completed by all members of staff. | Janet Hagerty | January 2017 |

| Page Number | Improvement Needed | Standard | Practice Action | Responsible Officer | Timescale |
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| 10 | The practice must ensure that they comply with Control of Substances Hazardous to Health Regulations 2002 (COSHH). | 2.1; COSHH 2002 | Practice Manager has completed COSHH Training January 2017. Ongoing training will be provided in accordance with existing legislation. The assessments will be regularly revisited to ensure it is kept up to date and if there have been any changes in the workplace, equipment or products used. All assessments are kept in a single file in the Practice Manager's office and all staff have been made aware of this.<br><br>COSHH Assessment Forms have been completed for all chemicals used within the surgery. COSHH items are stored within a locked cupboard. Supplier has been changed to ensure the products and equipment are safely used and that they conform with COSHH requirements. All cleaning chemicals are in appropriately labelled containers. PPE is provided i.e. gloves, apron and worn whilst handling at all times. | Janet Hagerty | January 2017 |

| Page Number | Improvement Needed | Standard | Practice Action | Responsible Officer | Timescale |
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| 10 | The practice must ensure that they carry out environmental risk assessments and fire risk assessments to identify and manage any risks within the practice environment. | 2.1; Health and Safety Executive | A Fire Risk Assessment has been carried out on 19th January 2017. This was carried out by Fire & Security Solutions. The report has been received and the Action Plan completed which stated fire extinguishers to be checked and dated clearly – this has been arranged and completed by Fire Rite. Operating labels for fire extinguishers to be affixed near the extinguishers – this has been arranged and completed by Fire Rite. It was also recommended that a 9 litre water extinguisher or 6 litre with enhanced striking power should be fitted close to the exit door in the south corridor. This has been arranged and fixed by Fire Rite. A 'running sign' to be placed on Emergency Door 2 has now been installed. It was also recommended that the fire alarm system is tested at the same time and day weekly and a log kept for inspection. This has now been | Janet Hagerty | March 2017 |

| Page Number | Improvement Needed | Standard | Practice Action | Responsible Officer | Timescale |
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| | | | initiated and carried out by Rose George who is the nominated member of staff for this action (if unavailable Janet Hagerty).<br><br>An Environmental Risk Assessment has being carried out by the Practice Manager. Documentation relating to fire safety matters are collated in a single file, together with the Fire Risk Assessment. Staff training has been carried out to include what to do on discovering a fire, how to raise the alarm and when, procedures for alerting members of the public and visitors and directing them to exits. Arrangements for calling the fire service. Evacuation procedure for everyone in the premises to reach a nominated assembly point and place of safety. Location and use of fire fighting equipment. All staff has received online training in Fire Safety. Designated officer responsible for fire safety is Janet Hagerty and | | |

| Page Number | Improvement Needed | Standard | Practice Action | Responsible Officer | Timescale |
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| | | | deputy is Rose George. A record file of training and fire drills has been put in place. | | |
| 11 | The practice must ensure that there are formalised emergency arrangements in place in regards to contingency planning and managing significant health emergencies. | 2.1; Health and Safety Executive | The practice has a protocol in place for significant health emergencies e.g. swine flu epidemic. All equipment is available on site (Personal Protection Equipment). All staff are aware of what to do in this type of emergency. If the main surgery is unable to be used for some reason e.g. fire at this time we are able to use our branch surgery. All necessary contact numbers for electricians, builders, water board etc. are located within the reception area. | Janet Hagerty | December 2016 |
| 11 | The practice must ensure that there is a clear infection control policy in place, that all staff are aware of their responsibilities in regards to the policy and that the policy is readily available to all staff. | 2.4 | Infection Control Policy has been reviewed and updated.<br>All staff are aware of their responsibilities in regards to the policy and it is available to all staff in paper form and also on the desktop under Practice Policies. | Lynne Thomas | January 2017 |

| Page Number | Improvement Needed | Standard | Practice Action | Responsible Officer | Timescale |
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| 12 | The practice must ensure there are systems in place to monitor infection control standards and take action to comply with infection control guidelines. | 2.4 | The practice has an Infection Control Policy in place which all staff are aware of. This is kept in a separate section of the Practice Policies and includes needlestick injuries, hand washing signage; PPE equipment to be used where necessary and all staff concerned are aware of this. Audits are undertaken for any minor surgery performed.<br><br>Infection control measures will be monitored on an ongoing basis by both the Practice Manager and Practice Nurse who will also take spot checks on the cleanliness of the surgery. They will also be responsible for any relevant audits or risk assessments. A log is kept of spot checks and any actions that may be required.<br><br>Hand hygiene and any other relevant training will be undertaken by all staff. A record will be kept in their individual file of any training | Lynne Thomas<br><br>Janet Hagerty | February 2017 |

| Page Number | Improvement Needed | Standard | Practice Action | Responsible Officer | Timescale |
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| | | | undertaken.<br><br>We take measures to reduce the risk of infection between patients and staff i.e. hand sanitizers are placed in reception area, waiting area, toilets, consulting rooms together with paper towels, soap dispensers. Staff take responsibility for their own role and have received training in Infection Control which will be ongoing in the future. There will be discussion in practice meetings regarding Infection Control matters.<br><br>All staff - clinical, administrative and housekeeping wear a suitable uniform for the working environment.<br><br>Cleaning is done on a daily basis and different colour mops and buckets are used in specific areas e.g. minor surgery theatre, lobby area. PPE is worn. | | |

| Page Number | Improvement Needed | Standard | Practice Action | Responsible Officer | Timescale |
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| | | | | | |
| 12 | The practice is required to provide HIW with evidence of Hepatitis B vaccination and subsequent immunity records for all members of the clinical team. | 2.4 | Evidence is available of clinical members of staff Hepatitis B vaccinations. The phlebotomist has now received her full course of Hepatitis B vaccines.<br>Until the phlebotomist's antibody results were available she continued to use glove/apron protection when carrying out her phlebotomy duties whilst being mentored by the Practice Nurse. The phlebotomist had a risk assessment by her course trainer at Ysbyty Ystrad Fawr and was deemed safe to perform phlebotomy duties. | Janet Hagerty | March 2017 |
| 13 | The practice should review all Type 2 diabetic patients to ensure that there is consistent prescribing of statins and that sufficient detail is kept where individual prescribing practice falls | 2.6 | All Type 2 diabetic patients were reviewed December 2016 and it was found that out of all those on the Diabetic register five of the patients' had declined Statins. | Lynne Thomas | December 2016 |

| Page Number | Improvement Needed | Standard | Practice Action | Responsible Officer | Timescale |
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| | outside recommended guidelines. | | This has been recorded in the patients' medical records. | | |
| 14 | The child protection and POVA policies require review and updating to ensure they include sufficient detail, local referral numbers and that they comply with All Wales legislation and guidance. | 2.7 | The child protection and POVA policies have been reviewed, added into policies and updated. They include sufficient detail, local referral numbers and they comply with the All Wales Legislation and guidance. All staff have been made aware of the policies. The policy is accessible via the desktop. All local referral numbers are available on the notice board in reception area. These have recently been updated and this was discussed in our practice meeting. (March 2017) and the previous contact numbers have been replaced. | Janet Hagerty | Completed January 2017 |
| 14 | The practice must ensure that all staff are up to date with child protection and vulnerable adults training at a level appropriate to their role. | 2.7 | All staff have completed Child Protection Training up to level 2. Clinical Staff have completed up to level 3. All staff have been registered for online training, which they can access at a given time by the Practice Manager and | Janet Hagerty | March 2017 |

| Page Number | Improvement Needed | Standard | Practice Action | Responsible Officer | Timescale |
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| | | | complete courses applicable.<br>All staff have completed Vulnerable Adult training level 1 and are in the process of completing level 2.<br>Staff have also shown an interest in attending 'day out training' and this will be considered in the near future. | | |
| 15 | The practice must ensure that there is a formalised process in place, understood and adhered to by all staff, in managing correspondence coming into the practice and to ensure this happens in a consistent and timely manner. | 3.2:3.4 | All correspondence is acted upon daily. A nominated member of staff opens, date stamps and scans all the mail. The mail is then readcoded by either Practice Nurse or Practice Manager. If a member of staff is unavailable to scan the mail the Practice Nurse or Practice Manager picks up the correspondence, scans and readcodes all the mail. If the nurse or manager is not available for some reason the GP will readcode the scanned mail. This is done consistently on a daily basis. | Janet Hagerty | Completed |
| 16 | Staff should ensure that there is a | 3.2; 3.4 | A book is held in reception area for | Janet | Completed |

| Page Number | Improvement Needed | Standard | Practice Action | Responsible Officer | Timescale |
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| | clear internal process in place which demonstrates accountability in passing on and actioning messages. | | passing on and actioning messages by all staff. All staff are required to inspect the book daily, initial and action any necessary messages. This has been reiterated in a practice meeting. An Internal Message Policy is available and all staff are aware of this. The Practice Manager checks the message book daily when she is not available Rose George checks the book. We also have a book to write any deaths that may have occurred. All telephone encounters from patients are logged into the computer system together with a written telephone consultation form which the person who takes the message signs and the person who actions the message e.g. GP also signs as actioned. We also use the Daybook Tasks in Vision which are seen daily by everyone who log onto Vision. | Hagerty | December 2016 |
| 16 | The practice should review all internal | 3.2; 7.1 | For telephone encounters from | Janet | Completed |

| Page Number | Improvement Needed | Standard | Practice Action | Responsible Officer | Timescale |
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| | communications systems to consider whether improvements could be made and to ensure there is sufficient formalisation and accountability built into systems. | | patients who require a telephone consultation/telephone prescription forms are filled out and given to the GP to action. These are initialled by the GP and kept in a separate file for a minimum of one month. The member of staff who has taken the message is required to action any queries where possible, or pass it to someone who can. | Hagerty | December 2016 |
| 19 | The practice must ensure that patient's paper records are stored in line with national legislation requirements. Specifically, that patient records currently stored behind reception, are securely stored. | 6.2; 3.4; 3.5 | The practice is moving towards a full electronic system and all patients' paper records will be scanned and available electronically. Staff will be offered overtime to complete this action. Until such time the door through to reception area is to be kept locked at all times. | Janet Hagerty | December 2017 |
| **Quality of management and leadership** | | | | | |
| 20 | The practice must ensure that there is sufficient practice management time available to enable staff to fulfil their responsibilities. | Governance, Leadership and Accountability ; 7.1 | Part-time staff are currently in discussion with a view to increase their current hours of work. Plans are also in place to probably close the branch surgery which will free | Dr Das | September 2017 |

| Page Number | Improvement Needed | Standard | Practice Action | Responsible Officer | Timescale |
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| | | | up the receptionist who is currently covering to make up her hours in the main surgery. This will enable more practice management time to be available. | | |
| 20 | Staff should clarify which whistleblowing policy is currently in place and should be able to demonstrate that all staff have been made aware of this policy. | 7.1 | There were two whistleblowing policies within the Practice Policy file which had been duplicated. One has been updated and one has now been removed. All staff have been made aware of the whistleblowing policy that is in use, given a copy and advised that all policies are now on the desktop for access. | Janet Hagerty | Completed<br>January 2017 |
| 21 | The practice should ensure that all mandatory policies and procedures are in place, contain sufficient detail and are updated on a regular basis. Policies and procedures should be communicated to staff to ensure consistency of working practices and clarity over staff's roles and responsibilities. The practice should consider improving the organisation of policies and procedures so that | Governance, Leadership and Accountability ; 7.1 | All mandatory policies are being updated and this is being documented as each one is updated.<br>Policies have been organised and have been located on the desktop of each pc for staff to easily access them.<br>All staff are aware of this. | Janet Hagerty | March 2017 |

| Page Number | Improvement Needed | Standard | Practice Action | Responsible Officer | Timescale |
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| | they are easily located and accessible when needed. | | | | |
| 22 | The practice must ensure there is a formalised recruitment procedure in place which adheres to national legislation and guidelines. The practice must ensure that any staff now working at the practice, who were recruited without adhering to these guidelines, are suitably assessed for their fitness to undertake their roles and that all relevant checks are undertaken in order to safeguard both staff members and patients. | 7.1 | If in the future we need to recruit a new member of staff we will follow a formalised recruitment procedure which adheres to national legislation and guidelines when applicable for employing new members of staff<br>All members of staff have been assessed for their fitness to undertake their roles and all relevant checks have been undertaken e.g. DBS certificates. | Janet Hagerty | January 2017 |
| 23 | The practice must ensure that all staff stay up to date with ongoing training requirements. | 7.1 | All staff have now been registered for online training and are able to access the NHS Portal freely. For any future training which is required off site, staff will be allowed to attend for their ongoing training requirements at an allocated time and quiet area of the building. Training requirements will be discussed in our practice meetings. All staff have an | Janet Hagerty | Ongoing |

| Page Number | Improvement Needed | Standard | Practice Action | Responsible Officer | Timescale |
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| | | | individual file and courses completed are kept in each one. Practice Manager ensures that all staff have complied with statutory and any other necessary training. All training is ongoing and updated as necessary. All staff are aware of the necessity of continuing training requirements. The Practice Manager will ensure that staff are kept up to date with training requirements by practice meetings. | | |

**Practice representative:**

**Name (print): .....Janet Hagerty.....**

**Title: .....Practice Manager.....**

**Date: .... .....23rd January 2017 .....**