Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

General Practice Inspection (announced)

Aneurin Bevan University Health Board,

Aber Medical Centre

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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 Aber Medical Centre, 30 Thomas St, Abertridwr, Caerphilly CF83 4AZ on 8 December 2016. Our team, for the inspection comprised of two HIW inspection managers (one inspection lead and one observer), a GP peer reviewer, a practice manager peer reviewer and two representatives from Aneurin Bevan Community Health Council.

HIW explored how Aber Medical Centre met the standards of care set out in the Health and Care Standards (April 2015).

Inspections of General Medical Practice (GP) inspections 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

Aber Medical Centre currently provides services to approximately 5000 patients in the Abertridwr area of Caerphilly. The practice forms part of GP services provided within the geographical area known as Aneurin Bevan University Health Board.

Aber Medical Centre operates as one practice from two separate buildings which are located across the road and a short walk from each other. The phlebotomists, counsellor, secretaries and midwives operate from number 30 Thomas Street, (signposted as the Meddygfa Tridwr building). The GPs and nurses operate from number 27-29 Thomas Street (signposted as the Aber Medical Centre building). There are two branch surgeries located at Bedwas Health Centre, East Avenue, Bedwas, Caerphilly, CF83 8AE and Llanbradach Branch, Rear of Church Street, Llanbradach, Caerphilly, CF83 3LS.

The practice employs a staff team which includes four doctors, one nurse prescriber, one practice nurse, one health care assistant, three phlebotomists and a number of administrative and reception staff. The staff team works flexibly across all sites. There is one practice manager, one assistant practice manager and one finance manager who tend to each be based at each of the three sites. The practice manager's primary base is Aber Medical Centre.

The practice provides a range of services (as cited on the practice website), including:

- Phlebotomy (Bloods)
- Health promotion clinics
- Chronic disease clinics including; asthma, diabetes, coronary heart disease, chronic obstructive pulmonary disease, hypertension
- Baby clinic
- Child health surveillance
- Cervical screening
- Smoking cessation
- Travel vaccinations
- Counselling for drug &/or alcohol dependency
- Depression and wellbeing clinics

- Minor surgery
- Acupuncture.

3. Summary

Overall, we found evidence that Aber Medical Centre provides safe and effective care.

This is what we found the practice did well:

- Patients were happy with the service provided
- Patient records were of a good standard
- Staff we spoke with were happy in their roles and felt well supported
- Staff were proactive in making improvements to services and we could clearly see where changes had been made, e.g. improving access to appointments.

This is what we recommend the practice could improve:

- Staff's awareness and the practice's compliance with health and safety law and policy required improvements, including ensuring appropriate environmental risk assessments are carried out and actioned
- Staff require training in child and adult safeguarding and a protection of vulnerable adults policy needs to be put in place
- Ensuring that staff training needs are monitored and captured and that staff receive support to complete mandatory training on an ongoing basis.

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. 81 questionnaires were completed in total. Overall, patient satisfaction was high.

We found people were treated with dignity and respect by staff. The practice had a system in place to enable patients to raise concerns/complaints and the practice was able to demonstrate that they considered patient feedback to improve 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 high. Patients made positive comments about facilities and the service they received from the staff and practitioners.

A number of patients indicated that they had to wait longer than 48hours to see a GP of their choice. The numbers decreased if patients were happy to see any GP, however, over a quarter of patients still reported waiting for longer than 48 hours for an appointment. Patients also expressed difficulties in using the telephone booking system. It was positive to note that the practice had recently reviewed their appointments system as a whole and had made significant changes to try to improve this. Patients also raised concerns about access. This is addressed below.

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.

We considered the physical environment in both buildings and we found that patient confidentiality and privacy had been considered and the physical environment had been adapted, as much as would allow. Reception areas in

both buildings were separated from the waiting area by built up desks and clear perspex screens. The screens could be adjusted and rolled back when needed, to enable better communication. This gave privacy to staff answering the telephone and enabled documents to be shielded from view. Staff also told us that they could use private rooms to discuss any sensitive issues with patients, to maintain confidentiality. Staff could attend to patients using wheelchairs at the reception desk, through side door access from the reception area into the waiting area.

Doors to individual consultation and treatment rooms were kept closed when staff were attending to patients. This meant staff were taking appropriate steps to maintain patients' privacy and dignity during consultations.

In the records we reviewed we saw that GPs had documented patients' consent to examinations, the use of chaperones and full details of the advice offered to patients. There was a notice displayed which explained how patients' confidential information was used. This required some amendments to ensure it was accurate, which the practice manager agreed to make.

There was a written policy on the use of chaperones and staff told us that, primarily, clinical staff, who were clearly trained in this area, acted as chaperones. However, at times, non clinical staff acted as chaperones and staff told us they had not received training around their roles and responsibilities in this regard. This meant there was a need for non clinical staff to receive training to ensure that working practices fully protected patients and practice staff. The right to request a chaperone was advertised through posters in patient areas.

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.

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 not, 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)

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

waiting area at the Aber Medical Centre building but not at the Meddygfa Tridwr building.

Improvement needed

Complaints information should be displayed at all sites.

There was also some complaints information on the website. This meant, overall, that patients could easily access this information from the practice should they require it. The written procedure was comprehensive and 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.

We saw that staff maintained records of complaints. From the records we inspected, we could see that staff had taken appropriate action and had adhered to specified timescales in reaching a resolution.

The practice gathered patient feedback through patient questionnaires, when required, or for specific pieces of work. The most recent patient feedback the practice had collected was around one year ago when they had asked for patient views on the appointment system. They had used this feedback to make improvements to this system and this had reduced waiting times.

Staff told us that they were not currently considering implementing a patient participation group to provide feedback on services. The practice should consider formalising the process of gathering their own patient feedback so that they can demonstrate that patients are supported to provide feedback on an ongoing basis.

Delivery of safe and effective care

Overall, we found the practice had arrangements in place to promote safe and effective patient care, although some attention was required in terms of health and safety requirements. We found a staff team who were patient centred and committed to delivering a high quality service to their patients.

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

The practice had reviewed the appointments system as a whole, including the consideration of patient feedback and had made significant changes as a result to improve timely access to care and treatment.

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

Internal communication systems had been reviewed and new systems had been put in place which aimed to avoid unnecessary delays in referrals, correspondence and test results. This was working effectively.

There was a child protection policy in place but not a protection of vulnerable adults policy and staff had not completed up to date training in these areas.

The practice was housed in two buildings which had not been purpose built, were old and lacked space. Improvements are needed to ensure the practice adheres to health and safety policy and to ensure that full risk assessments are undertaken and followed through. 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. The practice must also ensure there are arrangements in place to promote equality of access to services regardless of patients' mobility requirements.

<u>Staying healthy</u>

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 a wide range of information available to help patients to take responsibility for their own health and well being. There was some 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. There was information available for carers, however, this was minimal and staff were not aware of any other local services or support available to carers. The practice maintained a carers' register and there was a sign displayed in reception encouraging carers to register. We suggested the practice nominate a carer's champion to promote knowledge, links to external support organisations and best practice 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)

The practice was housed in two buildings which had not been purpose built, were old and lacked space. Staff were aware of the challenges this brought and told us about the investments they had made to try to improve the environment and patient experience, however, challenges remained.

During a tour of the practice building, we found all areas occupied by patients to be clean and uncluttered which reduced the risk of trips and falls. The practice building was suitably maintained externally; however, internally we noticed some works that required attention, for example, peeling paint in one of the treatment rooms and fixtures for lighting in the staff room requiring replacement.

Improvement needed

Staff must ensure that any outstanding internal maintenance and repair works are carried out.

Staff were unsure whether an electrical installation inspection/check had been carried out within the last five years and if a gas safety check was carried out annually.

Improvement needed

The practice must ensure that electrical installation and gas safety checks are carried out in line with specified timescales.

There was a health and safety policy in place but this requires review and updating to ensure it covers all mandatory areas. There were other policies in place which covered aspects of health and safety such as waste management and sharps injuries. However, the policies available did not cover all health and safety requirements and in some cases required updating. We advised staff to consult the Health and Safety Executive to ensure they complied 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.

We found that there was a display screen equipment policy held at the practice. However, staff had not 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 within the environment, we were not assured that risks had been fully assessed or actions taken to minimise them. Staff had not completed a health and safety/environmental risk assessment. 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 to identify and manage any risks within the practice environment.

We saw that fire safety equipment had been checked and serviced. A fire risk assessment had taken place in March 2016. However, there was nothing recorded within the assessment to identify actions taken as a result of the assessment. We could see that some actions had been taken within the environment, such as the addition of some signage. However, accountability for the fire risk assessment and taking forward actions to mitigate risks needs to be clarified. It was unclear whether any recent fire training had taken place.

Improvement needed

The practice must ensure that fire risks are assessed, fully considered, advice followed and actions taken to minimise risks clearly documented. Staff must review the fire risk assessment and ensure all actions have been taken, as advised, to minimise risks. Staff should be trained in the actions to take in the event of a fire.

Although risks to business continuity had been considered informally, there was a lack of a plan and formalised arrangements to manage disasters and significant health emergencies.

Improvement needed

The practice must ensure there are formalised plans and arrangements in place regarding business continuity and responding to 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. However, we noticed there was some paint peeling from the ceiling in one treatment room above the bed. Staff agreed to address this immediately.

Improvement needed

Staff must ensure that the paint peeling above the bed in the nurse's treatment room is remedied.

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. Staff told us that clinical waste was collected more frequently from one building than the other. They told us that on rare occasions, when clinical waste was full at Aber Medical Centre, they carried clinical waste bags across the road to be collected from Meddygfa Tridwr. There are infection control risks associated with this practice.

Improvement needed

The practice should review the frequency of the clinical waste collection from both buildings and ensure that arrangements are appropriate.

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 was a clear and detailed infection control policy in place. Staff told us they had not carried out any assessment or audit to asses or monitor the environment for infection control risks.

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.

Senior staff described that all clinical staff were expected to ensure they received Hepatitis B vaccinations as required to protect themselves. There was a register in place to record this but it had not been updated since 2010 and was not currently actively monitored.

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].

There was a pharmacist who worked across their Neighbourhood Care Network (NCN)[2] and gave support to the practice. The pharmacist undertook medication reviews, including in person and home based reviews where required.

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 child protection policy in place and flowcharts displayed around the practice which included local contact numbers for reporting. There was no policy in place around the protection of vulnerable adults (POVA) and how to report suspected abuse or concerns regarding vulnerable adults.

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

[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.

Improvement needed

The practice must implement a POVA policy. This must comply with All Wales legislation and guidance and should be sufficiently detailed with local contacts, to guide staff in managing POVA matters.

Senior staff told us that the GPs had received training in child protection. However, the staff team as a whole lacked training in child protection and the protection of vulnerable adults. 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. Child safeguarding meetings took place every three months within the practice. 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 had recently been employed through the NCN to provide further support to practices around these matters.

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 were able to follow through the actions taken in relation to one significant event and clearly saw how working practices had changed as a result. This meant that learning from significant events was implemented to make improvements.

Staff told us meetings were held to update the whole staff team on any changes to practice but that these tended to be informal and not always minuted. We advised the practice to minute meetings to demonstrate an audit trail and as a way of recording the decisions made. We suggested 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 themes 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 in different formats for patients on request and could use interpreting services when needed.

The practice had established systems for the management of external and internal communications. Arrangements were in place to ensure clinical information received at the practice was recorded onto patients' records and shared with relevant members of the practice team in a timely manner.

A new system had been implemented approximately 12 months ago to record and manage all requests for tasks to be done in the practice. We reviewed this and found staff were using the system well and it was effective in practice. Staff also told us that investment had been made in scanning facilities to ensure that, across all sites, information could be easily uploaded onto patient records in a timely way. This meant the practice team were considering their systems and making improvements where required to ensure effective working.

Staff advised that they received discharge summaries from secondary care electronically within Aneurin Bevan University Health Board and an electronic system was used to manage referrals. GPs met regularly to review referrals and outcomes which worked as a monitoring mechanism.

An electronic system was in place to manage out of hours referrals and there was a system in place to ensure these were read and actioned in a timely way.

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.

In reviewing records we saw that a small number of diabetic patients had not received annual reviews within that timeframe and some were out of date by around three months. Staff explained that they experienced difficulties in encouraging patients to attend and we were assured that there was a current focus on encouraging this.

We saw that records were not reviewed or audited in terms of quality and we suggested the practice consider doing this to further encourage review and good standards of record keeping.

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, 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. The out of hours information in the leaflet required updating to ensure it was accurate.

Improvement needed

Out of hours contact numbers should be updated to ensure they provide accurate information to patients.

We were told that 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 waiting areas. This included information on local support groups, health promotion advice and self care management of health related conditions.

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. The practice had reviewed the appointments system as a whole, including the consideration of patient feedback, and had made significant changes as a result. Patients could book urgent appointments on the same day and routine appointments were available from one to three weeks in advance. Staff told us that they would always try to accommodate anyone who had an urgent need for an appointment on the same day.

The nursing team were able to see patients presenting with minor general illnesses (described as non urgent) if needed and these sessions had been increased as a result of the appointments system review. 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.

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 according to people's individual needs based on this knowledge. We saw that the practice had implemented an initiative called 'Improving Outcomes for Older People' which involved service adjustments to better meet the needs of older people. This was a good example of the practice proactively working to meet their population's individual needs.

Staff told us they experienced difficulties in accessing Child and Adolescent Mental Health Services for their patients and this was being addressed through the NCN. Links with these services are essential in ensuring young people receive preventative support in a timely way.

The practice buildings were not purpose built and as a result there were challenges within the environment to facilitate equal access. At the Meddygfa Tridwr site there was sloped access and a narrow doorway making it particularly challenging for those patients using wheelchairs to access. At the Aber Medical Centre site there was level access with an automatic door and two disabled parking bays outside. The practice had also invested in making patient toilets at this site as accessible as possible. We spoke with two patients with mobility needs and one patient told us the surgery had been able to accommodate them at the Aber Medical Centre due to their mobility needs. However the other patient told us that an adjustment had not been made to support them to access the practice from the more accessible site. Staff told us some services were currently only offered at Meddygfa Tridwr e.g. counselling.

Improvement needed

The practice should ensure that all patients, regardless of mobility needs, are offered an equitable service. The practice must ensure that reasonable adjustments are made to meet patients' needs and where this is not possible, plans and arrangements should be in place to ensure that patients are able to access the same services.

At the Aber Medical Centre site there was a tannoy to call patients into their appointments, whilst at Meddygfa Tridwr staff called patients into their appointments in person. Across both sites, staff knew patients well and reception staff called patients into their appointments when prompts were needed.

Arrangements were in place to protect the privacy of patients.

Quality of management and leadership

The practice had a clear management structure in place and flexibility within the team. We found a patient-centred staff team who told us they were well supported. We advised the practice to ensure they were monitoring and supporting staff compliance with ongoing training requirements.

Staff were able to demonstrate where they had reflected on practices and systems and made changes and improvements as a result.

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 effective leadership and a stable, patient-centred staff team who were committed to providing the best services they could to their patients. Staff told us that a new GP had recently joined the practice and as a result, some new ideas and ways of working were being promoted and encouraged throughout the staff team. Staff were open to this, appeared proactive in making improvements and were able to demonstrate that some practices had already changed as a result. Staff were given administrative time to support this. Staff told us they felt able to raise concerns and were positive about the support they received from senior staff.

There was a whistleblowing policy in place which identified appropriate routes for staff to raise concerns.

The practice had a range of relevant written policies and procedures to guide staff in their day to day work. In some cases these required review and updating. Senior staff had set time aside to start to review and update policies.

Improvement needed

The practice should ensure that policies are updated, and communicated to staff on an ongoing basis.

Staff working within the practice often took on dual roles. This meant that staff could provide cover for each other during absences, reducing the risk of disruption to services for patients. Most of the staff team worked across both

the main practice and branch surgeries which meant there was flexibility where needed.

A number of meetings were held at the practice, (including a weekly clinical meeting), to facilitate communication between staff and the staff we spoke with felt able to call their own meetings in between these times. Staff told us they also met to discuss practice issues in an informal way. We saw minutes for some meetings but not all. 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.

Staff told us about audits they carried out as a way to monitor and improve practice. We could also clearly see where changes had been made as a result of new ideas and patient feedback in order to the improve services for patients. The practice had a detailed and reflective Practice Development Plan which they had developed through their NCN. The practice was redeveloping their Llanbradach site which would provide a new environment and facilities for patients.

Senior staff from the practice 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. The nurse team was proactive in seeking support from the health board where needed and told us they received good training opportunities.

The NCN currently provided a pharmacist, social worker and wound care specialist as additional support roles to the practice.

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)

Discussions with staff and a review of policies and small sample of staff records indicated they had the right skills and knowledge to fulfil their identified roles within the practice.

Staff were able to describe their roles and responsibilities and indicated they were happy in their roles. Senior staff had recently started to carry out annual appraisals with staff 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. We saw that meaningful action had been taken as a result of discussions in appraisals.

We looked at the HR and recruitment documentation in place and found that appropriate checks were carried out prior to employment. Staff gave us positive feedback about the induction process.

All staff we spoke with confirmed they had opportunities to attend relevant training. However, staff told us there were sometimes difficulties in ensuring there was enough time allocated to allow them to keep up to date with training. The practice did not currently assess staff's training needs either individually or as a whole team 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 should ensure they can demonstrate how staff are supported to 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 Aber Medical Centre 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: Aber Medical Centre

Date of Inspection: 8 December 2016

Page Number	Improvement Needed	Standard	Practice Action	Responsible Officer	Timescale
Quality of the patient experience					
7	The practice should ensure that non clinical staff acting as formal chaperones are made aware of the requirements and responsibilities this role entails.	4.1	All existing staff to have physical in-house chaperone training and sign register of competency	CRD	3 months/ Inhouse training ongoing
8	Complaints information should be displayed at all sites.	6.3	Complaints information reviewed and new information displayed in all sites	CRD	Complete
Delivery of safe and effective care					
10	Staff must ensure that any outstanding internal maintenance and repair works are carried out.	2.1; Health and Safety Executive	Maintenance in Treatment Room to be carried out and ceiling issues made good, light fittings to be	CRD	1 month Completed

Page Number	Improvement Needed	Standard	Practice Action	Responsible Officer	Timescale
			checked and changed as necessary		
10	The practice must ensure that electrical installation and gas safety checks are carried out in line with specified timescales.	2.1; Health and Safety Executive	Practice has recently had inspection prior to visit although this was not confirmed until recently. Certificates to be provided	CR	2 month
11	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	To be implemented in all areas. New policy being revised and completed with view to be implemented within 2 months	CRD	2 months
11	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	To be implemented in all areas	CRD	3 months
11	The practice must ensure that they comply with Control of Substances Hazardous to Health Regulations 2002 (COSHH).	2.1; Health and Safety Executive; COSHH 2002	To be implemented. Risk assessment being created and completed with all hazardous substances reviewed	CRD	2 months
12	The practice must ensure that they carry out environmental risk	2.1; Health and Safety	Online training for management under process to enable	CRD	2 months

Page Number	Improvement Needed	Standard	Practice Action	Responsible Officer	Timescale
	assessments to identify and manage any risks within the practice environment.	Executive	appropriate risk assessments		
12	The practice must ensure that fire risks are assessed, fully considered, advice followed and actions taken to minimise risks clearly documented. Staff must review the fire risk assessment and ensure all actions have been taken, as advised, to minimise risks. Staff should be trained in the actions to take in the event of a fire.	2.1; Health and Safety Executive	To review the recent risk assessment reports again and take necessary actions recommended. All urgent or immediate action is currently being undertaken. Fire alarms in branch site being installed to comply with regulations	CRD/CR	ongoing
12	The practice must ensure there are formalised plans and arrangements in place regarding business continuity and responding to significant health emergencies.	2.1; Health and Safety Executive	To review old business continuity and amend accordingly	CRD/MGP	6 months
13	Staff must ensure that the paint peeling above the bed in the nurse's treatment room is remedied.	2.4; 2.1; Health and Safety Executive	Maintenance in Treatment Room to be carried out and ceiling issues made good	CRD	1 month/ Completed
13	The practice should review the frequency of the clinical waste collection from both buildings and	2.4	To review the waste situation and amend either waste bin size or increase collections	CRD/CR	3 months/ Reviewed –

Page Number	Improvement Needed	Standard	Practice Action	Responsible Officer	Timescale
	ensure that arrangements are appropriate.				outcome for this resulted that the branch site was not made open when collections undertaken resulting in a backlog of waste. This is now corrected and waste collected on a regular basis.
13	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	New infection control matrix underway and quarterly reviews to be undertaken and stored appropriately	CRD/CD	3 months
14	The practice is required to provide HIW with evidence of Hepatitis B vaccination and subsequent immunity	2.4	An up to date register to be amended and forwarded to HIW	CRD	1 month Completed

Page Number	Improvement Needed	Standard	Practice Action	Responsible Officer	Timescale
	records for all members of the clinical team.				
15	The practice must implement a POVA policy. This must comply with All Wales legislation and guidance and should be sufficiently detailed with local contacts, to guide staff in managing POVA matters.	2.7	To create and put in place a new POVA policy that complies with All Wales Legislation. Contact numbers to be displayed in each reception area for use. Staff to complete online training for POVA	CRD	3 months
15	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 to be allocated training time for completion of online training in child protection and POVA. This will also be incorporated into the induction process for new staff	CRD/MGP	6 months
17	Out of hours contact numbers should be updated to ensure they provide accurate information to patients.	4.2	Number to be amended when new practice leaflets are printed, until reprint numbers to be manually changed on leaflet. Website to be updated. Telephone system to be updated by provider	CRD	1 month for phone – completed and website update 3 months for new leaflet
19	The practice should ensure that all patients, regardless of mobility needs,	6.2; Equality Act 2010	Services provided in our more difficult to access site to be offered	CRD/SH	6 months

Page Number	Improvement Needed	Standard	Practice Action	Responsible Officer	Timescale
	are offered an equitable service. The practice must ensure that reasonable adjustments are made to meet patients' needs and where this is not possible, plans and arrangements should be in place to ensure that patients are able to access the same services.		to patients experiencing difficulties in the site with more suitable access. This service to be advertised on all sites		
Quality of management and leadership					
20	The practice should ensure that policies are updated, and communicated to staff on an ongoing basis.	Governance, Leadership and Accountability ; 7.1	All policies and procedures to be reviewed and updated as necessary	CRD/MGP	6 months
22	The practice should ensure they can demonstrate how staff are supported to stay up to date with ongoing training requirements.	Governance, Leadership and Accountability ; 7.1	To ensure a complete training record of staff, a new record containing all training needs and certificates to be put in place on the main site of surgery.	CRD	6 months

Practice representative:

Name (print): .....Claire Rees.....

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

Date: .....20th January 2017.....