Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection (Announced)

Blaen-Y-Cwm Group Practice/Aneurin Bevan University Health Board

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales are receiving good care.

Our values

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

Our priorities

Through our work we aim to:

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

1. What we did

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Blaen-Y-Cwm Group Practice, Blaina Rd, Brynmawr, Ebbw Vale, NP23 4PS within Aneurin Bevan University Health Board on 3 May 2017.

Our team, for the inspection comprised of an HIW inspection manager (inspection lead), GP and practice manager peer reviewers and a lay reviewer.

HIW explored how the service met the Health and Care Standards (2015).

Further details about how we conduct GP inspections can be found in Section 5 and on our website.

2. Summary of our inspection

Overall, we found evidence that Blaen-y-Cwm Group Practice provided safe and effective care. However, we found some evidence that the practice was not fully compliant with all Health and Care Standards in all areas.

This is what we found the service did well:

- Overall, patients we spoke with were happy with the service provided
- There was a well established patient participation group (PPG)
- There were arrangements in place to promote safe and effective patient care
- There were good systems in place for staff teams to meet regularly and staff told us communication between the health board and frontline staff worked well.

This is what we recommend the service could improve:

- Ensuring information for patients is comprehensive and easily accessible to all
- Ensuring all clinical waste is stored appropriately on an ongoing basis
- Review of the security alarm system to ensure appropriate risk management
- Staff's awareness and the practice's compliance with health and safety law and policy required improvement
- Staff training in some areas required updating e.g. child and adult protection. The current system of capturing staff training made it difficult to monitor ongoing training compliance and identify training needs.

3. What we found

Background of the service

Blaen-Y-Cwm Group Practice currently provides services to approximately 10,000 patients in the Brynmawr area. The practice forms part of GP services provided within the area served by Aneurin Bevan University Health Board.

The practice employs a staff team which includes five doctors, one practice manager, one deputy practice manager, one lead nurse and nursing team and a number of reception and administrative staff.

There are two branch surgeries at Aparajita Surgery, 68 Worcester Street, Brynmawr, NP23 4EY and Nantyglo Medical Centre, Queen Street, Nantyglo, Brynmawr, NP23 4LW. Staff work across all sites and the majority of services are also provided across all sites.

The practice is managed by Aneurin Bevan University Health Board.

The practice provides a range of services (as stated on their website), including:

- Cervical cytology
- Minor surgery
- Contraceptive services
- A variety of clinics including disease, family planning and child health
- Flu vaccination.

Quality of patient experience

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

Overall, patient satisfaction in this practice was high. Patients gave positive feedback about how they were treated by staff, the cleanliness of the practice and the care provided. Patients were less satisfied with the appointments system. There were plans in place to improve this.

We found people were treated with dignity and respect and supported to stay healthy, however, carers' support should be more fully explored. We advised the practice to make improvements to patient information (website, leaflet and displays) to ensure information is comprehensive and accessible to all. Overall, we found robust internal systems in place, however, there was a need to further develop the referrals system. There was also a need to ensure that the purpose of collecting confidential information from patients was clear.

The practice had a system in place to enable patients to raise concerns/complaints but complaints information should be made more visible and easily accessible. The practice had an established patient participation group (PPG) in place and was able to demonstrate that they considered patient feedback to improve services.

During our inspection we distributed HIW questionnaires to patients to obtain views on the services provided. A total of 17 questionnaires were completed. The majority of completed questionnaires were from patients who had been a patient at the practice for more than two years. We also spoke informally with patients to obtain their views. Overall, patient feedback was positive. Patient comments included the following:

Staff take time and explain…They listen to you

Staff all brilliant

I think the care's good

Patients were asked how the practice could improve the service it provides and comments included the following:

Later (evening) hours

Assess and review the current process of making appointments.

Staying healthy

There was some information available to help patients to take responsibility for their own health and well being. There was minimal carers' information.

Health promotional materials were provided through leaflets in the waiting area. These were stored on a shelving unit and were not well organised. This meant that there were challenges in being able to access appropriate health promotional material in an easily accessible way. This is addressed in the patient information section below.

The practice maintained a carers' register. There was information available for carers, however, this was minimal and staff were not aware of local services or support available for carers. We suggested the practice nominate a carers' champion to promote knowledge, links to external support organisations and best practice around carers' needs.

The nurse told us about a positive initiative being implemented by the nursing team in terms of health promotion, with the introduction of a rolling health promotion theme across all practices, with corresponding display boards being organised.

Improvement needed

The practice must be able to demonstrate how they consider carers' needs and further develop how they support carers.

Dignified care

We found that people were treated with dignity and respect by staff. Every patient who completed a questionnaire felt that they had been treated with

respect when visiting the practice. We observed staff greeting patients both in person and by telephone in a polite, friendly and welcoming manner. Staff were sensitive and caring when supporting one patient who was particularly unwell on the day.

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.

We considered the physical environment and we found that patient confidentiality and privacy had been considered and the physical environment had been adapted to support this, as much as would allow. For example, the reception area was separated from the waiting area by a built up desk which enabled documents to be shielded from view. Staff could attend to patients using wheelchairs at the reception desk, through side door access from the reception area into the waiting area. There was some space behind reception that was also shielded from view and gave privacy to staff using the telephone. Staff also told us that they could use other areas of the practice to discuss any sensitive issues with patients, to maintain confidentiality, for example, the downstairs staff area. Although there was a shortage of space available, staff had an awareness of protecting patient confidentiality and used the environment to do this, within the limitations it provided.

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 they had received training in this role. This meant that there were working arrangements in place which aimed to protect patients and practice staff. The right to request a chaperone was advertised through posters in patient areas. We suggested that this information could also be added to the locum GP pack.

Patient information

Information for patients about the practice's services was available within a practice leaflet. This provided some useful information, including details of the practice team, opening hours and the procedure for obtaining repeat prescriptions. However, information about the appointments system and complaints procedure should be improved to ensure it is comprehensive. The patient information leaflet was not routinely made available in the waiting area. There was some information available on the practice's website which could be improved to ensure it is detailed and helpful for 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 proactively how to make their practice leaflet more accessible to those patients who speak different languages or those patients requiring large print or other accessible formats.

There were a range of health promotional and other information leaflets in the reception area. However, the way they were stored meant that different health topics/areas were not clearly visible and a lack of organisation meant that there was a need to search through leaflets to find what was relevant. We advised the practice to ensure that patient information is easily accessible. Other key practice information was on display such as out of hours service information.

In the patient records we reviewed there was evidence to demonstrate that clinicians involved patients in their care and treatment and provided them with information in order to assist them in understanding their health care and treatment. We saw that GPs had documented where they had requested and obtained patients' consent to examinations.

Improvement needed

The practice must ensure that the practice information leaflet and website provide full, comprehensive information. Staff should review these sources of information and provide more detail where needed, for example, around the complaints procedure and appointments system. Staff should ensure health promotional materials are clearly displayed and easy to access.

The practice must ensure that information is provided in a language and format that meets the needs of patients, including those patients who speak Welsh.

Communicating effectively

Staff told us that they could use interpreting services when needed. None of the patients who completed a questionnaire considered themselves to be a Welsh speaker so it was not possible to find out how often patients had been able to speak to staff in Welsh. All patients, however, indicated that they were always able to speak to staff in their preferred language. The practice had a hearing loop which they used to aid communication with those patients with hearing difficulties.

All patients who completed a questionnaire confirmed that they were asked questions about their medical problem when they were making an appointment. Over half of patients said that they did not know why. We advised staff to

consider how to improve communication with patients around the reasons for requesting information from them and how this assists staff in deciding the priority and order of appointments (triage system).

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, including correspondence, test results and out of hours information. There was a robust system for recording any patient deaths. There was a robust electronic internal messaging system in place which aided communication between staff members.

We reviewed five discharge summaries and we saw that where these were produced and received by Aneurin Bevan University Health Board, they were of a good quality and were received electronically. We saw that there was variable quality where discharge summaries were received from other health boards and where they were handwritten. There was a system for ensuring these were recorded onto patient records.

Timely care

The majority of patients who completed a questionnaire were fairly satisfied with the hours that the practice was open with two comments requesting extended opening times. We saw that the surgery tried to accommodate patients outside of office times and was open until 6.30pm Monday to Friday.

Patients were able to book appointments by telephone or in person at any of the three practices; they could also book and cancel appointments using the online service, My Health on Line.

The appointments system had been adapted over time to try to improve patients' experience in accessing appointments. Patients could book urgent appointments on the same/next day and routine appointments were available from one to two 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.

However, a large proportion of patients who completed a questionnaire said that it was not very easy to get an appointment when they needed it. There was also a mixed response to the question that asked patients how they would describe their experience of making an appointment. While many patients indicated that they had a very good or good experience, a similar number of patients felt that they had a poor or very poor experience making an

appointment. Staff told us they were reviewing the appointments system with a view to make further improvements. We saw that the health board was increasing the number of nurse practitioners at the practice and planned to reinstate nurse triage (nurses deciding the urgency and order of appointments) as they told us this had worked well in the past.

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.

On the day of the inspection there was a medical emergency. This meant that there was a delay in patients accessing appointments. Staff notified patients of the delay once prompted. However, staff should consider how they ensure patients are kept up to date on waiting times in the event of an unexpected delay in the future.

There was a referral policy in place which guided staff in making referrals. Staff told us that there was not currently a system in place to ensure referrals had been received and acted upon and referral rates were not currently audited within the practice.

Improvement needed

The practice must ensure there is a robust system in place to monitor and record referrals, ensuring that they have been received, particularly where these are urgent. Staff should consider auditing referrals with a view to reviewing current systems and improving practice where this may be possible.

Individual care

Planning care to promote independence

We saw that the practice reviewed their effectiveness in identifying and meeting the health needs of those who need regular personal health checks. As a result, appropriate patient reviews were planned and carried out. We saw that regular multi-disciplinary team meetings were organised where this was appropriate in planning patients' care, for example, for those patients requiring palliative care.

We saw that those patients with additional needs were flagged on the electronic system to alert staff, for example, those patients with learning disabilities and/or mental health issues. The practice should consider how to improve information

for those patients who may be harder to reach, particularly those who may not access the practice often.

People's rights

We saw that equality and diversity training was mandatory and provided by the health board. Due to difficulties in accessing training information, we were unable to assess whether staff had undertaken this training. Management staff told us they would review compliance and ensure staff completed this training.

We saw that the patient registration form collected some equality and diversity information. However, we found some questions asked some particularly personal questions and when questioned, practice staff were unclear about the reason for collecting this information at registration. We also found that, at the same time, some key patient information was not currently collected through the form. This meant that staff had not fully considered the purpose of information collection and patient's rights in regards to sharing only that information which was key to this purpose.

Improvement needed

The practice must ensure that they are adhering to legislation regarding information governance and the collection of patient data. The practice must review its patient registration form and collect only data that is necessary for this initial stage of patient contact. Staff must be aware of their responsibilities under information governance legislation. Patients should be informed of how and why their personal information is being collected and their rights regarding data collection.

Listening and learning from feedback

The practice had a written procedure in place for patients to raise concerns and complaints. 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 Community Health Council (CHC) as an advocacy service with making complaints.

There was a lack of complaints information on display apart from some generic 'Putting Things Right' leaflets. There was some complaints information on the website and in the patient information leaflet but this was limited. This meant, overall, that patients could not easily access this information. Patient

questionnaires reflected this and more than half of patients who completed questionnaires did not know how to raise a concern or complaint about the services they receive at the practice.

We saw that staff maintained records of complaints. We saw that complaints were considered at clinical meetings as a way to share learning.

There was a well established Patient Participation Group (PPG) in place which met regularly and the practice used this as a mechanism to listen and learn from patient feedback. The contact details for this group were displayed in reception and we saw that there were details about how new members could join. Staff were considering how this group could be used more, for example, in initiatives such as promoting flu vaccinations. The PPG were involved in ongoing consultation over the new build that was due for completion in November. We suggested staff also consider how to empower patients to provide feedback in other ways, on an ongoing basis.

Improvement needed

Complaints information should be visibly displayed and easily accessible for patients.

Delivery of safe and effective care

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

Overall, we found the practice had arrangements in place to promote safe and effective patient care, although attention was required in terms of some health and safety requirements.

We have asked the practice to make improvements to health and safety across a number of areas. For example, ensuring in-house fire checks take place in line with fire regulations, ensuring security is effectively managed and that they meet all health and safety requirements as advised by the Health and Safety Executive (HSE).

We found suitable infection control arrangements in place. However, there was a need to update the Hepatitis B register and ensure that clinical waste was appropriately and securely stored on an ongoing basis.

Suitable arrangements were in place to ensure the safe prescribing of medicines

There was a child protection policy in place. The protection of vulnerable adults policy needed to be more practice-focussed and we could not be assured that staff had completed up to date training in these areas.

There were appropriate arrangements in place to learn from any patient safety incidents.

The sample of patient records we reviewed were of a good standard with some aspects which could be improved.

Safe care

Managing risk and promoting health and safety

The practice had been built in the 1990s and with the increase in demand, was now limited in space. Patients were asked how easy they found it to get into the building and there was a mixed range of responses. We saw that all patient services were provided on the ground floor which meant that patients did not have to negotiate stairs and we found that, although limited in space, patients using wheelchairs could access the building. There was clear signage to direct patients. A new build was currently underway, due for completion in November 2017, which would allow for increased space and improved accessibility for all patients.

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 and internally. We noticed one of the radiator covers was broken in the waiting area and a nail was exposed which could be a hazard. Staff agreed to resolve this as soon as possible.

We found that the security alarm was currently not in use. Staff told us that this was due to a fault on the system and ongoing discussions around who would act as keyholders (health board representatives or practice staff members). Our concerns regarding the practice's security alarm system were dealt with under our immediate assurance process. This meant that we wrote to the practice immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in Appendix B.

There was a health and safety policy in place but this required review and updating to ensure it covers all mandatory areas. The policies we reviewed did not cover all health and safety requirements. We advised staff to consult the Health and Safety Executive to ensure they complied with all relevant health and safety requirements.

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.

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). Staff told us that a health and safety advisor from the health board was due to visit in June 2017 to complete this assessment and offer further advice.

We saw that an environmental risk assessment had been undertaken up to 2011 and actions had been carried out to address risks identified. However, this required updating to ensure that all risks had been fully assessed and actions taken to minimise them. 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). Staff told us that the health and safety advisor from the health board would address this during their scheduled visit.

We saw that fire safety equipment had been checked and serviced. On inspection of records, we found that documentation for the servicing and maintenance of fire equipment at one of the branch surgeries was not available. The health board investigated this following the inspection and arranged for this to take place at the branch surgery as soon as possible. Fire risk assessments had taken place across all three practices in November 2016 and health board management staff advised that all issues had been logged with the health board and were being addressed. We saw that in house fire alarm checks had not been logged in the fire logbook since 2014 and we advised staff that these checks must recommence in line with fire regulations. We saw that the fire blanket had been removed from its holder in the staff area and we advised management staff to replace this.

There was a practice risk register, business continuity plan and practice contingency plan in place. The business continuity planning was up to date and comprehensive. This meant there were plans in place to limit disruption to services in the event of an emergency.

We checked emergency equipment at the practice, which was held centrally in an emergency bag. The contents of the emergency bag, although comprehensive, were not easily accessible. We suggested the practice consider how to organise their stocks better to make it easier to access what was needed. We found there were no paediatric pads that could be used for the defibrillator and staff agreed to order these as soon as possible.

Improvement needed

Staff must ensure that the exposed nail in the waiting room is covered.

The health board must provide assurance to HIW that they have sufficiently assessed and taken action to mitigate the risks of not using a security alarm system at the practice.

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

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.

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

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

Staff must carry out specified in house fire checks and record these in the fire logbook, in line with fire regulations. The fire blanket in the staff area should be replaced into its holder.

Paediatric pads are required for use with the defibrillator.

Infection prevention and control

We found the practice environment to be generally clean. The majority of patients who completed a questionnaire felt that, in their opinion, the practice was very clean.

Staff confirmed they had access to personal protective equipment, such as gloves and disposable plastic aprons, to reduce cross infection. The clinical treatment areas 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. There was a

system for clinical waste to be securely stored until it could be safely collected. However, on the day of the inspection, we found three full clinical waste bags being stored inappropriately in a staff area, due to the main clinical waste bin being full. Staff told us this was due to a public holiday meaning that the regular collection had not happened as it usually would. We raised this with management staff and the lead nurse resolved this immediately, disposing of the clinical waste bags. Staff must take action to ensure that this does not reoccur.

There was a clear and detailed infection control policy in place. One member of the nursing team had been designated as the lead for infection control which meant that they had some delegated responsibility to ensure the practice stayed up to date with infection control policy and guidelines. Staff had carried out an infection control audit to assess and monitor the environment for infection control risks.

Senior staff told us that all clinical staff were expected to ensure they received Hepatitis B vaccinations. There was a register in place to record this but it had not been updated to reflect the current immunisation status for all staff.

Improvement needed

Staff must ensure that the issue with public holiday collections of clinical waste is resolved and must take steps to ensure that the inappropriate storage of clinical waste will not reoccur in the future.

The practice is required to provide HIW with evidence of Hepatitis B vaccination and for those staff who do not respond to the vaccination, risks associated with this must be assessed.

Medicines management

We found that suitable arrangements were in place for the safe prescribing of medicines to patients. There was a pharmacist who worked across the

practice's Neighbourhood Care Network (NCN)[1] and gave support to the practice.

We found suitable arrangements in place to ensure that medication reviews took place on an ongoing basis and medicines that were no longer needed, were removed from the repeat prescribing list.

Patients could access repeat prescriptions by calling into the surgery in person and by email. The practice used the health board's formulary[2].

We checked emergency medication and where checked, found them to be within date.

There was an appropriate arrangement in place to report adverse reactions to drugs.

We saw that any medicines errors were reported through the significant events process and reviewed at significant events meetings. The pharmacist also reviewed the prescribing system and any medicines errors to provide support.

Safeguarding children and adults at risk

There was a child protection policy in place which included local contact numbers for reporting. There was a health board generic protection of vulnerable adults (POVA) policy in place but a lack of local and practice specific information available to staff about how to report suspected abuse or concerns regarding vulnerable adults.

Due to the way training information was captured, it was difficult to assess whether all staff had completed safeguarding training at a level appropriate to their role. Senior staff told us that the GPs had received training in child

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[1] **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.

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

protection up to level three and they planned for the nursing team to train to this level in the near future. There was a lack of training around the protection of vulnerable adults. Therefore, we could not be assured that all staff were sufficiently trained to identify and manage child and adult protection issues.

We looked at the process in place for flagging child and adult safeguarding cases on the electronic system. We saw that children on the child protection register were recorded on the electronic system but this was not immediately clear and visible. The process for recording when children remained or were removed from the register could also be improved.

We saw that multi-disciplinary working took place around child safeguarding concerns.

Improvement needed

The practice must ensure there is a POVA policy in place which complies with all Wales legislation and guidance and is sufficiently detailed with local contacts, to guide staff in managing POVA matters.

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

Staff must review where they record details relating to children's status on the child protection register ensuring that this is in a prominent place, immediately visible, clearly marked and dated.

Effective care

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 at fortnightly clinical meetings. The records we viewed confirmed that review took place with relevant members of the practice team in this way.

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.

There was a system in place for patient safety alerts to be sent to clinicians where these were relevant for primary care. The health board provided free training sessions on topics relevant for GPs and nursing staff. The NCN also played a role in ensuring the practice stayed up to date with best practice and current ways of working across the area. Staff told us new National Institute for Health and Care Excellence (NICE) guidelines were discussed at clinical meetings but this was not always recorded. We suggested the practice have a NICE guidelines slot on the agenda as a prompt and record of these discussions.

Information governance and communications technology

We found that there were health board information governance policies and procedures in place.

Record keeping

We looked at a random sample of electronic patient records and, overall, found a good standard of record keeping.

The records we reviewed were up to date, complete, understandable and had been completed contemporaneously, (or within appropriate timescales for home visits). Records included all the key basic information required such as date, time, inputter etc. which ensured a clear audit trail.

We found that clinicians were consistently recording when they obtained patient consent and when they ordered investigations.

We found particularly good practice in the coding of patient records by dedicated and experienced staff. We suggested that this could be further

improved by adapting a common READ coding[3] protocol. We found in a small number of records that consultations were not specifically READ coded.

Where patients suffered from significant and long term conditions we found that records included full summaries of these conditions.

We found that reasons for discontinuing medication were consistently recorded. However, recording of the indications for prescribing medications could be improved.

Overall, 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. However, there was some inconsistency in this regard, particularly in recording evidence and reasoning for decisions relating to patient care. We also found that the recording of examination findings was not consistent and could be improved, especially regarding the recording of negative findings.

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

We found that patient paper records were being stored in unlocked cupboards in a staff area. Records were being transferred onto the electronic system during weekend working hours so that paper records could be archived. The practice must ensure that their storage arrangements comply with data protection legislation.

Improvement needed

The practice is required to demonstrate how improvements to record keeping will be made in the areas as identified in the report including:

[3] **Read codes** are the standard clinical terminology system used in General Practice in the UK. It supports detailed clinical encoding of multiple patient phenomena including: occupation; social circumstances; ethnicity and religion; clinical signs, symptoms and observations; laboratory tests and results; diagnoses; diagnostic, therapeutic or surgical procedures performed; and a variety of administrative items.

- Consistent READ coding of consultations
- Consistent recording of the indications for prescribing medications
- Consistent recording of the evidence and reasoning for decisions relating to patient care
- Consistent recording of examination findings (particularly the recording of negative findings)
- Review of storage of patient paper records to ensure the practice is compliant with data protection legislation.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how services review and monitor their own performance against the Health and Care Standards.

The practice had been going through a time of change over the last two years and there had been a number of changes to some of the staff team. The health board managed the practice and we received positive comments about communication between practice staff and health board management staff.

We found a patient-centred frontline 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 and that staff were clear regarding which policies and procedures governed their working practices.

Governance, leadership and accountability

We found that the practice had been going through a time of change and as a result there had been a number of changes to some of the staff team and senior management. The practice had become health-board managed in July 2015. The practice had also merged with another local practice in October 2016, which meant an increase of approximately 1,600 patients.

There was an interim practice manager in place who worked in another area of the health board. They had been in post for two weeks and were undertaking this role until a permanent practice manager could be recruited. The health board's Primary Care Operations Support Team were also supporting practice staff, with the aim of enabling the practice to run as independently as possible in the future.

Despite a number of changes and challenges, we found a staff team who were committed to providing the best services possible to their patients. Some staff had been working at the practice for many years and so provided a degree of consistency. Staff were positive about the support they received from

management staff within the health board and both practice and health board staff told us they felt communication worked well.

Staff told us they felt able to raise concerns and there was a health board whistleblowing policy in place which identified routes for staff to do so.

The practice had a range of relevant written policies and procedures to guide staff in their day to day work and these had started to be stored centrally for ease of access. However, some further organisation of policies, procedures and records was required. Staff were not always clear regarding whether there was a practice specific policy or health board policy within each area and how this applied to their working practices. We could not be assured that policies were regularly communicated to staff.

Some staff working within the practice took on dual roles and worked across all three practice sites. This meant that staff could provide cover for each other during absences, reducing the risk of disruption to services for patients.

A number of meetings were held at the practice, (including a fortnightly clinical meeting and regular nursing team meetings), to facilitate communication between staff. The minutes we saw demonstrated open communication, clear allocated actions and the sharing of learning across teams.

The practice had a Practice Development Plan which they had developed through their NCN. There were clear plans in place regarding the building of a new surgery and this was underway and due for completion in November 2017. Senior management staff had also reviewed staffing and skill mix and we could see that changes were being implemented with the aim to improve services. For example, the nursing team was being expanded and an increase in nurse practitioners was in progress. These were positive developments, given the changes and challenges the practice had faced.

Senior staff attended the NCN meetings and used this forum as a way to generate quality improvement activities and to share good practice. The nursing team also attended practice nurse meetings which involved an element of continued professional development and helped to keep them informed of practice developments. The nursing team appeared proactive in supporting each other and taking action to improve services.

Improvement needed

Management staff must ensure that there is clarity around policies and procedures and when health board policies or practice-specific policies apply. The staff team must be clear as to which policies and procedures govern their

working practices.

Staff and resources

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. 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.

We looked at the Human Resources (HR) and recruitment documentation in place and found that appropriate checks were carried out prior to employment. All recruitment was centralised and adhered to health board policies and procedures.

Staff gave us positive feedback about the induction process and we saw that this was being further formalised and developed by a senior staff member. We suggested that the induction process could include more detail around patient contact. We also advised the practice that the locum pack could be improved to include more information around chaperones, vulnerable patients, carers and the practice policies to manage these groups.

All staff we spoke with confirmed they had opportunities to attend relevant training and that this was well supported by the health board. 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.

Staff told us that the health board had overall access to each staff member's individual training records. Practice staff were using two databases as sources of information regarding staff training, as records were now also being stored on the health board's central training database. Senior administration staff had been working hard to ensure that relevant training had been placed on the system for completion. However this meant that, at the time of the inspection, the practice management staff were unable to see, at a glance, where there were gaps in training and where staff required updates. From the records we reviewed, we could not be assured that staff were up to date with mandatory training or that training needs were effectively identified.

Improvement needed

Practice management staff must be able to identify staff training needs through use of the database. The practice must ensure they can demonstrate how staff are supported to stay up to date with ongoing training requirements.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measureable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

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

5. How we inspect GP practices

GP inspections are usually announced. GP practices will receive up to 12 weeks notice of an inspection. This is so that arrangements can be made to ensure that the practice is running as normal, and that the inspection causes as little disruption to patients as possible.

Feedback is made available to practice representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

We check how GP practices are meeting the Health and Care Standards 2015. We consider other professional standards and guidance as applicable.

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

Further detail about how HIW inspects the GP practices and the NHS can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
We found three full clinical waste bags being stored inappropriately in a staff area, due to the main clinical waste bin being full. Staff told us this was due to a bank holiday which meant that the regular collection had not taken place.	This meant that risks associated with infection control had not been appropriately managed (Standard 2.4)	We raised this concern immediately with practice management staff.	The lead nurse appropriately disposed of the clinical waste by the end of our inspection. Management staff agreed to order an additional clinical waste bin to ensure this did not reoccur.

Appendix B – Immediate improvement plan

Service: Blaen-Y-Cwm Group Practice

Date of inspection: 3 May 2017

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
Finding: We found that the security alarm, used to ensure the building is safe and secure, is currently not in use. Staff told us that this was due to a fault on the system and ongoing discussions around who would act as keyholders (health board representatives or practice staff members). Given that some medicines, prescription pads and paper patient records are currently stored at the practice (records are left unlocked in staff areas overnight), the health board must be	2.1 Managing Risk and Promoting Health and Safety	The security alarm has been repaired. The Health Board has made arrangements for responding to call outs. The Health Board has considered the risks – all prescriptions/ prescription pads and medications stored on the premises will be stored securely.	Victoria Taylor – Head of Primary Care Linda Griffiths – Practice Manager	19/05/2017 Immediate

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
assured that the risks associated with not using an alarm system have been considered and addressed. We could not be assured that this had been considered or that a resolution would be reached in a timely way. Improvement needed: The health board must provide assurance to HIW that they have sufficiently assessed and taken action to mitigate the risks of not using a security alarm system at the practice.		The risk regarding the records will be mitigated when they are all transferred to central storage at SSP. This process has already commenced and will be expedited. Some of the cabinets that the records are held in are lockable and are secured.	Rachel Prangley/ Linda Griffiths	Already commenced and will be expedited for prompt completion

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print): **Rachel Prangley**

Job role: **Development Manager**

Date: **17/05/2017**

Appendix C – Improvement plan

Service: Blaen-Y-Cwm Group Practice

Date of inspection: 3 May 2017

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The practice must be able to demonstrate how they consider carers' needs and further develop how they support carers.	1.1 Health promotion, protection and improvement	Practice has displayed posters in the practice on the carers week 12th – 16th June with information and details of links to resources that may be of assistance to carers. Our documentation has been amended to include contact details for carers for records to be updated A member of staff will be nominated as	Practice Manager/ Deputy Practice Manager	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
		a Health Care Champion and will have the task of ensuring that all of the patient information in the practice is relevant, up to date and easily accessible for patients. A letter will be developed to send to all carers listed in the practice to provide them with comprehensive information of services that may be able to assist and support them such as Age Concern, Action for Hearing Loss and local support groups. This information will also be displayed in the practice and included in the practice leaflet and also on the practice website.	Practice Manager/Deputy Health Care Champion	Within 4 weeks 6-8 weeks
The practice must ensure that the practice information leaflet and website provide full, comprehensive information. Staff should review these sources of information and provide more detail where needed, for example, complaints procedure and appointments system. Staff should ensure health promotional materials are clearly displayed and easy to access.	4.2 Patient Information	Full details of how to raise a concern and the PTR process is on the practice website, practice leaflet and posters in the practice. The practice has ensured that this is now clearer for patients. The practice will review all of the patient information displayed in the practice and ensure that it is clear,	Practice Manager/ Deputy Practice Manager Health Care Champion	Complete Ongoing

Improvement needed	Standard	Service action	Responsible officer	Timescale
The practice must ensure that information is provided in a language and format that meets the needs of patients, including those patients who speak Welsh.		relevant and easy to access. Access to alternative languages would be provided upon request. The practice will obtain a Welsh translation for its practice leaflet.	Senior Administrator	2 weeks
The practice must ensure there is a robust system in place to monitor and record referrals, ensuring that they have been received, particularly where these are urgent. Staff should consider auditing referrals with a view to reviewing current systems and improving practice where this may be possible.	5.1 Timely access	All referrals are WCCG linked which displays the current position of the referral which is clearly indicated and monitored on a daily basis. The practice has also developed an additional policy to have another record of referrals on the staff's administration screen so they are able to track the new referrals at the request of the GPs.	Senior administrator	Already in place
The practice must ensure that they are adhering to legislation regarding information governance and the collection of patient data. The practice must review its patient registration form and collect only data that is necessary for this initial stage of patient contact. Staff must be aware of their responsibilities under information governance legislation. Patients should be informed of how and why their	6.2 Peoples rights	Patient registration form amended to ensure only relevant information is collected. The gathering of patient identifiable information and how it can be used is indicated in the patient leaflet and is also on the practice website with the link to Freedom of Information.	Practice Manager/ Deputy Practice Manager	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
personal information is being collected and their rights regarding data collection.				
Complaints information should be visibly displayed and easily accessible for patients.	6.3 Listening and Learning from feedback	Practice has poster and leaflets displayed in patient waiting areas and also included on the practice website. The practice has made this more visible for patients. The practice leaflet has also been updated to include full details. Staff supply complaint form at reception for patients to complete and the manager responds within the specified time period. The practice follows the "putting things right" process of Aneurin Bevan Health Board	Practice Manager/ Senior Administrator	Complete
Delivery of safe and effective care				
Staff must ensure that the exposed nail in the waiting room is covered. 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 Managing risk and promoting health and safety	The radiator cover has been repaired. Health and Safety policy on the practice administration drive for all staff to view. On 31st May a full	Practice Manager Practice	Complete Ongoing

Improvement needed	Standard	Service action	Responsible officer	Timescale
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. The practice must ensure that they comply with Control of Substances Hazardous to Health Regulations 2002 (COSHH). The practice must ensure that they carry out environmental risk assessments to identify and manage any risks within the practice environment. Staff must carry out specified in house fire checks and record these in the fire logbook, in line with fire regulations. The fire blanket in the staff area should be replaced into its holder. Paediatric pads are required for use with the defibrillator.		environmental and COSHH assessment was undertaken and the practice is awaiting a full report. There is a DSE policy on the administration drive for all staff to view. On checking with the IT department the practice has been informed that the computer screens within the practice are in line with current guidelines. The practice IT equipment will be having a refresh upon entering the new build and all new workstations will be set up in accordance with current guidance. A review and update has been undertaken for the COSHH items in the practice on the advice of the Health and Safety Officer.	Manager Practice Manager/Deputy Practice Manager Practice Manager/ Senior Nurse	Ongoing – workstation assessments to be fully completed in new build. Completed Ongoing

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Fire checks are undertaken on a weekly basis by trained staff. Fire blanket has been replaced in its holder during HIW inspection Paediatric pads have been ordered and placed in the Defibrillator bags	Practice Manager/Deputy Practice Manager Senior Nurse	Completed Awaiting Delivery
Staff must ensure that the issue with public holiday collections of clinical waste is resolved and must take steps to ensure that the inappropriate storage of clinical waste will not reoccur in the future. The practice is required to provide HIW with evidence of Hepatitis B vaccination and for those staff who do not respond to the vaccination, risks associated with this must be assessed.	2.4 Infection Prevention and Control (IPC) and Decontamination	Extra storage container has been provided at Blaen y cwm. Currently members of staff are having up to date blood tests to ensure compliance.	Practice Manager Senior Nurse	Completed Ongoing
The practice must ensure there is a POVA policy in place which complies with All Wales legislation and guidance and is sufficiently	2.7 Safeguarding children and adults at risk	The current POVA policy is on the G drive for staff to view. Training is also being undertaken for those staff that	Practice Manager	27th June

Improvement needed	Standard	Service action	Responsible officer	Timescale
detailed with local contacts, to guide staff in managing POVA matters. 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 must consider where they record details relating to children's status on the child protection register and ensure that this is in a prominent place, immediately visible, clearly marked and dated.		have not complied. Training scheduled for 27th June. All staff are required to complete mandatory online training and clinicians are required to attend their appropriate training sessions – the senior administrator has developed a robust training log and monitoring system. Policy amended (and staff informed) to show status of the child in the warning box on the front screen of the patient record and also that it is clearly displayed in patient records and linked to a problem so all records of adding and taking a child off of the register is clearly visible.	Senior Administrator/ all staff Senior Administrator/ all staff	Ongoing Complete
The practice is required to demonstrate how improvements to record keeping will be made in the areas as identified in the report including: □ Consistent READ coding of consultations □ Consistent recording of the indications	3.5 Record keeping	All problems are now linked to the prescribing which was discussed in the HIW visit and policy developed and discussed in practice meeting. All clinicians have been reminded to elaborate on the reasoning and decisions for the consultation.	Practice Manager/ Clinical Lead Clinical Lead	Complete Ongoing

Improvement needed	Standard	Service action	Responsible officer	Timescale
for prescribing medications □ Consistent recording of the evidence and reasoning for decisions relating to patient care □ Consistent recording of examination findings (particularly the recording of negative findings) □ Review of storage of patient paper records to ensure the practice is compliant with data protection legislation.		Further training will be given to clinicians and practice coders in respect of READ codes and ensuring a consistent approach. The practice is currently participating in the Scan and Store initiative, which provides centralised off site secure storage for patient medical records.	Clinical Lead/ ABUHB Clinical Lead Deputy Practice Manager/Senior Administrator	June 27th 2017 Ongoing
Quality of management and leadership				
Management staff must ensure that there is clarity around policies and procedures and when health board policies or practice-specific policies apply. The staff team must be clear as to which policies and procedures govern their working practices.	Governance, Leadership and Accountability	All policies are available to all staff on the G drive and in the staff handbook. All staff are ABUHB employees and as such work to ABUHB policies and procedures. Staff are notified of any changes/ updates. All applicable policies and procedures are saved on the G Drive for staff to access. Individuals always sign the Standing Operating Procedures and Patient Group Directives to understand their	Practice Manager/ Senior Nurse/ Clinical Lead	Ongoing

Improvement needed	Standard	Service action	Responsible officer	Timescale
		role in the care of the patients.		
Practice management staff must be able to identify staff training needs through use of the database. The practice must ensure they can demonstrate how staff are supported to stay up to date with ongoing training requirements.	7.1 Workforce	A CPD session for staff is planned on the 27th June where the staff will have the opportunity to undertake on line training for compliance of training. Also planned is 1-1 training around specific training needs for individuals. The IN house training is continual and refreshed with staff when needed All staff members also have an annual PADR, and new starters have one within 6 weeks, in order to establish current and future training needs and career aspirations.	Practice Manager Appropriate Line manager for staff member	Ongoing Ongoing on an annual basis

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): RACHEL PRANGLEY

Job role: SENIOR MANAGER – PCOST ABUHB

Date: 19/06/2017