Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection (Announced)

Tudor Gate Surgery/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 Tudor Gate Surgery, Tudor Street, Abergavenny, Monmouthshire, NP7 5DL, within Aneurin Bevan University Health Board on the 9 May 2017.

Our team, for the inspection comprised of a 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 Tudor Gate Surgery 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
- Excellent, comprehensive sources of practice and health promotion information were available for patients
- There were arrangements in place to promote safe and effective patient care across areas
- There were clear lines of accountability, staff felt supported and there were good systems in place for staff teams to meet regularly
- The practice was able to demonstrate a commitment to and investment in, making service improvements

This is what we recommend the service could improve:

- Formalising systems in place for patients to provide feedback on services

- Several aspects within the practice required improvement to ensure patients' privacy and confidentiality was suitably maintained
- Records and documents relating to infection control required implementation/updating
- Staff awareness of, and the practice's compliance with, health and safety law and policy required improvements. In light of the upcoming refurbishment work several health and safety aspects required immediate action
- Staff training in some areas required updating e.g. child and adult protection. The current system of organising staff training made it difficult to monitor ongoing training compliance and identify training needs.

3. What we found

Background of the service

Tudor Gate Surgery currently provides services to approximately 8,600 patients in the Abergavenny 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 four doctors (with one vacancy due to be filled in August), three nurses, two health care assistants, one practice manager, one assistant practice manager, three dispensers and a number of reception and administrative staff.

Tudor Gate Surgery is a training practice.

The practice provides a range of services including:

- Ante-natal clinic
- Cervical smear and Well Woman appointments
- Child immunisations
- Family planning
- Minor surgery
- Travel clinic

- Non-NHS services including medicals for pre-employment, insurance claim forms, passport signing, prescriptions for taking medication abroad, private sick notes and vaccination certificates.

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.

We found people were treated with dignity and respect, however, there were aspects of maintaining patient privacy within the environment that could be improved. Information was available to support patients to stay healthy and mechanisms were in place to support carers. There were excellent sources of practice and health information available to patients. We advised the practice to make improvements to ensure that information was made accessible in formats and languages that met the needs of the practice population. Welsh speakers must be able to communicate in Welsh where they choose to do so.

Overall, we found robust internal systems in place, however there was a need to review two aspects to ensure systems were robust.

The practice had a system in place to enable patients to raise concerns/complaints but this information should be made more visible. The practice was currently developing formalised ways of seeking patient feedback and this work should be progressed. The appointments system had been overhauled with the intention of improving patient experience and overall, patients were satisfied with this.

A major refurbishment of the environment was planned and it was clear that there was a commitment to invest in, and improve, the patient experience across a number of areas.

During our inspection we distributed HIW questionnaires to patients to obtain their views on the service provided at the practice. A total of 16 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.

Overall, patient feedback was positive. Patient comments included the following:

“Really good”

"Quite happy at the moment”

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

“Make appointments easier to get”

"More staff to answer the phone in the mornings when you phone to make an appointment”

Staying healthy

There was information available to help patients to take responsibility for their own health and well being and links to carers' support networks.

There was a wide range of health promotional materials available for patients, provided through leaflets, a television screen in the waiting area, and on the website. This included information about local services. This meant that patients could easily access information to support them in taking responsibility for their own health and wellbeing.

The practice maintained a carers' register. There was a carers' board in the waiting area which provided information about support and services for carers. One member of staff acted as a carers' champion to promote best practice around carers' support.

Dignified care

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

Almost all of the patients who completed a questionnaire felt that they had been treated with respect when visiting the practice, apart from one patient who felt that they were only treated with respect ‘sometimes’. In light of this comment, staff should consider whether there are any further measures they can take to ensure patients are consistently treated with respect.

We observed staff greeting patients both in person and by telephone in a polite, friendly and welcoming manner. We saw staff being particularly kind and caring to a child prior to their appointment.

We considered the physical environment and we found that patient confidentiality and privacy was protected as much as the physical environment would currently allow, in the reception and waiting areas. 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. Staff spoke discreetly with patients in these areas and conversations between patients and receptionists could not be overheard. At the time of the inspection some major refurbishment was planned and staff had considered how best to adapt the environment to further promote patient's privacy.

Doors to individual consultation and treatment rooms were kept closed when staff were attending to patients. However, we noticed that staff sometimes opened the windows of the consultation and treatment rooms which backed onto the car park. This meant that conversations could be overheard from outside. The type of blinds in use also meant that it was possible to see into these rooms at times, where staff were meeting with patients. This meant staff needed to take steps to maintain patients' privacy and dignity during consultations in these rooms. We also found that conversations between the prescribing clerk and patients could currently be overheard due to the temporary placement of the clerk in a room next to the waiting area.

In the records we reviewed, we saw that, overall, GPs had documented patients' consent to examinations.

There was a written policy on the use of chaperones and only staff who had received training took on this role. This meant that there were working arrangements in place which aimed to protect patients and practice staff.

Improvement needed

The practice must ensure that patient confidentiality and privacy is protected at all times. Specifically, measures must be put in place to protect patients' privacy in the consulting rooms which back onto the car park (open windows and insufficient cover from blinds) and in the temporary location of the prescribing clerk.

Patient information

Information for patients about the practice's services was available within a practice leaflet. This provided comprehensive and useful information, including details of the practice team, opening hours, some health promotion advice and the procedure for obtaining repeat prescriptions. Information was also displayed in the waiting area, through leaflets, posters and a television screen. This included information about practice news, for example, the planned refurbishment, to keep patients up to date. The practice also maintained a website which was an excellent comprehensive source of information.

We were told that the practice leaflet would be produced in other formats and languages on request and the registration form was currently available in different formats/languages. 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.

In the patient records we reviewed there was evidence to demonstrate that clinicians involved patients in their care and treatment.

Improvement needed

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. The practice had a hearing loop which they had just installed and planned to use to aid communication with those patients with hearing difficulties. We advised that

staff should be fully trained on using this once installed. One of the receptionists was also learning British Sign Language which was funded by the practice to support communication with some patients within their practice population.

Patients who completed a questionnaire who considered themselves as a Welsh speaker indicated that they were only 'sometimes' able to speak to staff in Welsh when they wanted to. All patients who completed a questionnaire who did not consider themselves as Welsh speakers indicated that they were always able to speak to staff in their preferred language. The practice must ensure that there are systems in place to enable Welsh speakers to communicate in Welsh.

All patients who completed a questionnaire confirmed that they are asked questions about their medical problem when they try to make an appointment; a third of patients said that they did not know why they were asked these questions when making an appointment. 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. Overall, 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. However, we found two aspects required review/improvement including:

- We found there were some instances where doctors did not review all incoming correspondence, including, for example, normal blood results. Although on investigation we felt assured that there was appropriate oversight, a formalised protocol should be in place which assesses any risks involved in clinicians not overseeing all correspondence/results (including normal blood results).

- We found that in the event of a patient death, this was recorded on patient records, however, the practice team and any other third parties involved in the patient's care were not currently alerted.

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 overall the quality was acceptable and they had been received within an appropriate timeframe.

Improvement needed

The practice must ensure that there are systems in place to enable Welsh speakers to communicate to staff in Welsh, where they choose to do so.

Two aspects of internal communication systems required review and improvement:

- Review of the system for correspondence and results, in some cases, not being seen by a clinician/doctor. Risks around this should be assessed and a formalised protocol put in place.
- Ensure that patient deaths are alerted to practice team and other parties involved in the patient's care.

Timely care

All patients who completed a questionnaire were satisfied with the hours that the practice is open. One patient did suggest that an improvement to the service the GP provides would be to “open at weekends”. We saw that the surgery tried to accommodate patients outside of office times and was open until 6.30pm Tuesday to Friday and 7pm on Mondays.

Patients were able to book appointments in person, by telephone and online. The appointments system had been reviewed and adapted over time to try to improve the patient experience in accessing appointments. Since January 2016 the practice had moved to a system whereby any patient requesting an appointment before 10am would be seen the same day. Patients with additional needs could book appointments in advance if this worked better for them. Staff told us they advised patients verbally if there was any delay when waiting to be seen. A small number of patients who completed a questionnaire felt that it was not very easy or not at all easy to get an appointment when they needed it. However, almost all patients who completed a questionnaire described their experience of making an appointment as either very good or good.

The nursing team were able to see patients presenting with minor general illnesses (described as non urgent) if needed. The nursing team also saw patients for yearly reviews of their chronic health conditions so that they could access the care and treatment they needed without having to see a doctor. The practice had moved away from a system of clinics to yearly reviews to enable

patients to access one appointment for a review of all conditions. This was changed with the intention of improving patient experience.

In regards to referrals, staff told us that referral patterns had been agreed and developed informally over time. We found that referrals were made in a timely way and there was a system in place to ensure referrals had been received, particularly in the case of urgent referrals. Some auditing of referral rates took place through the Neighbourhood Care Network (NCN)[1]. We reviewed some referral letters through our review of records and found them to be of a good standard.

Individual care

Planning care to promote independence

We found that patients who required them, were offered regular personal health checks, including vulnerable patients and those with additional needs, for example, patients with learning disabilities, mental health difficulties and patients with dementia. 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 staff communicated with other professionals and external agencies, where this was appropriate.

We saw that those patients with additional needs were flagged on the electronic system as a way to alert staff. Staff told us they offered longer appointments to patients where required, in order to meet their individual needs. We identified an area of noteworthy practice whereby the carers' lead was involved with patient reviews of vulnerable patients to ensure carers were identified and support offered to carers where appropriate.

People's rights

[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.

Staff had considered and described a number of ways in which they endeavoured to meet patients' individual needs throughout the patient journey.

We saw that the purpose of data collection from patients was explained on the practice's website and in their information leaflet. We suggested that the practice also advertise this in their waiting areas.

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.

Almost all patients who completed a questionnaire said that they knew how to access the out of hours GP service. However, almost two thirds of patients who completed a questionnaire did not know how to raise a concern or complaint about the services they receive at the practice. There was a lack of complaints information on display in the surgery apart from some generic 'Putting Things Right' leaflets. Complaints information on the website was difficult to find but there was some clear complaints information in the patient leaflet. This meant, overall, that access to this information could be improved.

Staff maintained records of complaints as an audit trail for actions taken.

Systems and mechanisms to allow patients and carers to provide feedback on an ongoing basis were being developed. Staff were in the process of setting up a Patient Participation Group (PPG). We saw that there were mechanisms on the website to allow patients to provide feedback, such as through the 'friends and family test' and submitting comments. Staff were able to demonstrate that they made changes as a result of listening to feedback, for example, we saw that the website had been updated to provide more detailed information about a particular health condition following some feedback from a patient who had requested this. However, systems to gather and review patient feedback required formalisation. 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

The practice must ensure there are systems in place that empower patients to provide feedback on services provided.

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 appropriate environmental and fire risk assessments are completed, particularly with an upcoming period of building work and ensuring that they meet all health and safety requirements as advised by the Health and Safety Executive (HSE) on an ongoing basis.

We found suitable infection control arrangements in place. However, there was a need to review security arrangements for the clinical waste bin. Attention was also required to update the infection control policy and to ensure the practice could demonstrate staff training in infection control and that any infection control risks were assessed and managed on an ongoing basis.

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

There was a child protection policy in place but a lack of a vulnerable adults' policy. 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 was of a good standard. We did, however, identify some aspects which could be improved.

Safe care

Managing risk and promoting health and safety

The practice had been built in the 1980s and with the increase in demand, there were now challenges with space. An extensive refurbishment was due to start imminently which planned to improve patient flow, accessibility and amenities. There was a clear aim to improve the patient experience through this investment.

Almost all patients who completed a questionnaire felt that it was very easy to get into the building. At the time, we saw that all patient services were provided on the ground floor which meant that patients did not have to negotiate stairs. There was ramp access so that patients using wheelchairs could access the building. The gradient of the sloped entrance from the pavement into the practice was steep and we advised staff to consider how to make this more accessible for patients using wheelchairs who may access the building without a carer/support to assist. Disabled toilet facilities were available. There was clear signage to direct 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.

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).

We saw that an environmental risk assessment had not been carried out within recent years. There is a legal duty to assess the risks to the health and safety of employees (and risks to the health and safety of persons visiting the premises).

We saw that fire safety equipment had been checked and serviced. We saw that in house fire alarm checks were taking place and being logged in the fire logbook. A fire risk assessment had taken place in 2012 but had not been updated since. We saw that actions identified in the assessment to reduce the risk of fire, had not been consistently addressed in the practice environment, e.g. it had been identified that no items should be stored under the stairs near to the fire exit. However, in practice we saw that this was being used as a storage area. Our concerns regarding the fire risk assessment 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. Fire safety training for staff was required.

We considered plans for the refurbishment work. We found that extensive refurbishment of the premises (including some structural work) was planned to take place imminently, with the practice staying open to patients through this time. The practice team were able to describe how they planned to minimise patient impact through this period of work. However, we found that health and safety risks had not been formally considered or assessed in terms of patients and employees continuing to access the building while this work took place. Current environmental and fire risk assessments were not up to date, as described above. This meant we could not be assured that all safety aspects (including environmental and fire risks) had been fully considered to maintain patient safety within the practice environment, with an imminent period of building work planned, when risks would be higher. Our concerns regarding this were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

There was a lack of formalised plans in regards to managing business continuity risks at the practice. We found there was a lack of a practice risk register and although there was a business continuity plan in place this had not considered how services would aim to continue in times of severe disruption. This meant that plans in place to limit disruption to services in the event of an emergency required further consideration and formalisation.

We checked emergency equipment at the practice and found equipment and medicines for managing emergencies to be within date.

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.

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.

The practice must ensure that all health and safety risks associated with the refurbishment work have been formally considered and assessed so that patient safety is protected during this time.

The practice must ensure that a fire risk assessment, carried out by an appropriately competent professional, is completed as soon as possible in order to inform the planned period of refurbishment work. Fire risk assessments should be kept up to date, monitored, with actions implemented to minimise risks within the environment on an ongoing basis.

Infection prevention and control

We found the practice environment to be clean. The majority of patients who completed a questionnaire felt that in their opinion the practice was very clean; the rest of the patients felt the practice was fairly 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. Carpet in clinical areas was planned to be replaced with more easily washable flooring as part of the refurbishment work. 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. We saw that the locked clinical waste bin was kept in the car park. This was secured to the wall by a thin metal chain and padlock. We could not be assured that this was sufficiently secure and we advised staff to review this.

There was an infection control policy in place. This required review to ensure it was up to date and reflected current working practices at the surgery. Staff told us that infection control training took place but this was not always formally recorded. We advised staff to record this as an audit trail. Infection control audits were not currently carried out. Therefore, we could not be assured that infection control risks within the environment, for example, washing of curtains, were assessed or monitored.

Senior staff told us that all clinical staff were expected to ensure they received Hepatitis B vaccinations. There was a central register in place to record this.

Improvement needed

Staff must review the security arrangements for the storage of the clinical waste bin in the car park to ensure this is sufficiently secure.

The infection control policy requires review to ensure it accurately reflects current working practices. Staff should be trained in infection control policy and procedures and evidence of this should be recorded.

Staff must ensure that they can demonstrate how infection control risks within the environment are assessed, monitored and actions take to address these risks, e.g. through infection control audits.

Medicines management

The practice both prescribed and dispensed medicines. We found that suitable arrangements were in place for the safe prescribing and dispensing of medicines to patients. There was a pharmacist who worked across the practice's NCN and gave support to the practice.

In the patient records we reviewed there was clear recording around the reasons for initiating medicines.

We found suitable arrangements in place to ensure that 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 via the MyHealth Online website. Staff told us that the formulary[2] was discussed at clinical meetings and had recently been reviewed by the pharmacist to ensure it was up to date.

We saw that the prescribing system was reviewed to include any errors and significant events, to ensure that any learning was shared.

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

Safeguarding children and adults at risk

There was a child protection policy which was up to date and included local contact numbers for reporting. A policy around the protection of vulnerable adults (POVA) policy was not in place and is required.

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. Staff we spoke with described some informal in-house training and were unsure regarding who was the practice lead and where to find relevant policies. We were told that the lead GP for child protection had recently left and staff needed to identify a replacement. Senior staff told us that clinicians had received training in child protection up to level two and they were currently working on level three as this is now a requirement. We could not be assured that training around the protection of vulnerable adults had taken place. 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, including vulnerable adults, on the electronic system and we found these to be appropriate.

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

We saw that multi-disciplinary working took place around child safeguarding concerns and there were regular meetings to share information and discuss cases.

Improvement needed

The practice must ensure there is a POVA policy in place that meets all Wales guidance and that all staff are aware of the policy and how it informs their working practices.

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

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 significant event meetings which included any member of staff involved. There wasn't currently a formal system for disseminating any learning to the wider team following this meeting and we advised staff to consider how they could share learning and encourage service improvements in this way.

There was a system in place for patient safety alerts to be sent to clinicians where these were relevant for primary care. Staff told us new National Institute for Health and Care Excellence (NICE) guidelines were not formally discussed and we suggested the practice consider implementing this.

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 recording when they obtained patient consent in the large majority of records. In a small number this could be improved.

Overall there was good practice in the coding of patient records, particularly in the Read coding of chronic diseases. It was positive to note that a great deal of work had been done in implementing templates to ensure consistency in both managing chronic diseases and ensuring consistent record keeping. In some cases we found that acute conditions/minor illnesses were not Read coded. This meant that patients' medications were not clearly linked to conditions within records in these cases and this could be improved.

Where patients suffered from significant and long term conditions we found that records included full summaries of these conditions, which meant useful background information was available to inform consultations.

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. In one case we saw detailed entries relating to the care and treatment of one elderly patient which demonstrated good practice in both record keeping and in providing continuity of care to the patient. There was evidence to show that patients were involved in treatment decisions, however, little evidence of written information being offered to patients. Staff assured us that they did this but did not always record it and we advised to record when this was done to support an audit trail.

We found that overall, records were being securely stored. However, we found a practice in place whereby the risks of breaching patient confidentiality were extremely high. We found that opened correspondence with patient identifiable information was being stored in wall mounted open drops, outside consultation/treatment rooms.

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.

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:

- Consistent Read coding of acute conditions/minor illnesses to ensure medications are appropriately linked to records
- Recording when patients are provided with written information

- Review of storage of patient paper records to ensure the practice is compliant with data protection legislation. The practice must ensure that all patient identifiable information is stored securely in line with the Data Protection Act 1998. Specifically, patient identifiable information must not be stored in open drops outside consultation/treatment rooms.

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.

We found effective management and leadership at this practice with clear lines of management and accountability. Staff were able to demonstrate their commitment to, and investment in, the improvement of services.

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 made aware of how to access the policies governing their working practices and could demonstrate that policies were communicated to staff.

Governance, leadership and accountability

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 were positive about the working environment and felt ownership over the practice. Staff told us they felt able to raise concerns and were particularly positive about the support they received from their colleagues, senior staff and how collective decision making took place.

The practice had a range of relevant written policies and procedures to guide staff in their day to day work. Although most of these were kept centrally on a shared drive, staff sometimes had difficulty in locating them. Some policies required updating. We also suggested that staff consider how to demonstrate that policies had been communicated to staff.

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.

We saw that a new meetings schedule had recently been put in place as a way to encourage the formalisation of communication systems across the practice. We saw that regular clinical meetings took place and the doctors and practice manager also met regularly. It was positive to note that Away Days had also taken place as a way to reflect on progress and to make changes and improvements to ways of working. The meetings schedule had been one outcome from a recent Away Day which demonstrated how new initiatives were implemented.

Staff carried out audits as a way to monitor and improve practice in addition to peer review and shared learning, where, for example, one GP had experience in a particular field. The practice had a detailed and reflective Practice Development Plan which they had developed through their NCN. This clearly identified the practice's aims and we could see that progress had been made across a number of areas.

Senior staff attended the NCN meetings and used this forum as a way to generate quality improvement activities and to share good practice.

Improvement needed

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

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.

At the time of the inspection, one GP partner had just left but a salaried GP had been recruited with a planned start date within 3 months. Cover was being provided in the interim by locum doctors. Aside from this, there was a stable staff team.

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 there was a recruitment policy and procedure in place and appropriate checks were carried out prior to employment.

There was a process in place to induct new members of staff and we saw that a checklist was used to record when staff had been inducted into each task.

All staff we spoke with confirmed they had opportunities to attend relevant training. Management staff told us that training was arranged on an adhoc basis and that processes for identifying training needs were informal. A mandatory training list was not in place and staff training was not recorded, so we could not be assured that staff were up to date in essential training such as safeguarding children and adults and fire training. This meant that management staff were unable to see, at a glance, where there were gaps in training and where staff required updates.

Improvement needed

Practice management staff must be able to identify staff training needs. 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
No immediate concerns were identified on this inspection.			

Appendix B – Immediate improvement plan

Service: Tudor Gate Surgery

Date of inspection: 9 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 extensive refurbishment of the premises (including some structural work) was planned to take place imminently, with the practice staying open to patients through this time. The practice team were able to describe how they planned to minimise patient impact through this period of work. However, we found that health and safety risks had not been formally considered or assessed in terms of patients and employees continuing to access the building while this work took place.	Health and Care Standards 2015 - 2.1 Managing Risk and Promoting Health and Safety; Health and Safety Executive (HSE)	The building refurbishment H&S risk assessment was undertaken by the Building Safety Group on 27 April 2017. There is a current building refurbishment Fire RA in place undertaken by the Building Safety Group on 27 April 2017. The practice fire risk assessment is	Interim PM Interim PM Interim PM	APRIL 2017 APRIL 2017 MAY 2017

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
We found that the current fire risk assessment was out of date, having last been completed in 2012. We saw that some recommendations from this were not being followed in practice e.g. under stairs area remaining clear. We found that environmental risk assessments were not being completed, to consider risks in the practice environment as a whole on an ongoing basis. This meant we could not be assured that all safety aspects (including environmental and fire risks) had been fully considered to maintain patient safety within the practice environment, with an imminent period of building work planned, when risks would be higher. Improvement needed: The practice must ensure that all health and safety risks associated with the refurbishment work have been formally considered and assessed so that patient safety is protected during this time. The practice must ensure that a fire risk		scheduled for 26 May 2017 by Fire Safety Adviser. All actions will be addressed, monitored and recorded appropriately and in conjunction with progress on the refurbishment.		

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
assessment, carried out by an appropriately competent professional, is completed as soon as possible in order to inform the planned period of refurbishment work. Fire risk assessments should be kept up to date, monitored, with actions implemented to minimise risks within the environment on an ongoing basis.				
Finding: We found a practice in place whereby the risks of breaching patient confidentiality were extremely high. We found that opened correspondence with patient identifiable information was being stored in wall mounted open drops, outside consultation/treatment rooms. Improvement needed: The practice must ensure that all patient identifiable information is stored securely in line with the Data Protection Act 1998. Specifically, patient identifiable information must not be	Health and Care Standards 2015 - 3.5 Record Keeping	Wall mounted drops were removed immediately.	Acting PM	10.5.2017

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
stored in open drops outside consultation/treatment rooms.				

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): **GM Willis**

Job role: **INTERIM PRACTICE MANAGER**

Date: **26 MAY 2017**

Appendix C – Improvement plan

Service: Tudor Gate Surgery

Date of inspection: 9 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 ensure that patient confidentiality and privacy is protected at all times. Specifically, measures must be put in place to protect patients' privacy in the consulting rooms which back onto the car park (open windows and insufficient cover from blinds) and the temporary location of the prescribing clerk.	4.1 Dignified Care	Windows have been ordered with integrated blinds and we will also have internal window blinds for the nurse clinical rooms. The prescription clerks will have allotted rooms when the reburb is completed; we are in the process of sorting their temporary allocation with the project manager	Interim PM Project Manager	Over the next month Over the next month
The practice must ensure that information is provided in a language and format that meets	4.2 Patient Information	We will begin to display posters etc in both welsh and English.	Interim PM	Over the next few months

Improvement needed	Standard	Service action	Responsible officer	Timescale
the needs of patients, including those patients who speak Welsh.				
The practice must ensure that there are systems in place to enable Welsh speakers to communicate to staff in Welsh, where they choose to do so. Two aspects of internal communication systems required review and improvement:	3.2 Communicating effectively	We are mindful of the requirements to produce information for our patients in a bilingual format. We have therefore arranged the following:- a) Message on TGS ansafone is bilingual (Welsh and English) to be completed by 31 July 2017. All staff to be given the link to learning Welsh on line by 31.8.17 b) Website: option to translate into language of choice (which addresses all languages including Welsh). Complete. Future recruitment to check Welsh language skills of applicants. c) TGS check in board - option to choose check-in in Welsh - selection by nationality flag. Complete. d) PTR : supplies of leaflets requested	Interim PM	31.07.2017

Improvement needed	Standard	Service action	Responsible officer	Timescale
		in Welsh and English by: 31 July. PTR posters in the waiting room in Welsh and English by 31.7.17 e) Newsletter: to be produced in Welsh on request by 31.8.17 f) Posters and Information : available in Welsh (on request) and English by 31.8.17 g) The timescale for some of these criteria will depend upon the stage of TGS refurbishment (currently Phase 2) and our ability to display information during Phases 5 and 6. h) TGS is fully committed to providing information in a bi and multi lingual format according to patient need/demand. i) Completion of partially integrated bilingual services by 31.7.17; fully integrated bilingual communications by		31.08.2017

Improvement needed	Standard	Service action	Responsible officer	Timescale
		January 2018 (on completion of the refurbishment of the surgery) j) We aim to set up a PPG and one of the tasks will be to survey patients for their feedback so that we are able to respond to patient need appropriately. k) Review of systems for monitoring correspondence and results. Protocol under review and revised system to be in place by 31.10.2017		31.10.2017
Review of the system for correspondence and results, in some cases, not being seen by a clinician/doctor. Risks around this should be assessed and a formalised protocol put in place. Ensure that patient deaths are alerted to		Practice Deaths: regular agenda item on		

Improvement needed	Standard	Service action	Responsible officer	Timescale
practice team and other parties involved in the patient's care.		Partners' Meeting agenda w.e.f. 31.7 2017 Protocol reviewed and published internally by 31.7.2017		31.07.2017
Complaints information should be visibly displayed and easily accessible for patients The practice must ensure there are systems in place that empower patients to provide feedback on services provided.	6.3 Listening and Learning from feedback	We have informed staff (who didn't know) where our complaints information is kept and we will organise its display for patients in the waiting areas. F&F in situ. Newsletter (eg. July 2017 – summer newsletter) published 19.07.2017 Posters in Welsh and English inviting patient feedback by 31.01.2018 – although interim measures as previously stated. Our website is continually updated with current information. Introduction of PPG to (constitution to	Interim PM	19.07.2017 31.01.2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		be written and agreed) and include inviting patient feedback/acting as patient liaison for non medical matters by 31.1.2018 Publication of newsletter on website by 31.8.17 Nominate a practice representative to engage with PPG on a bi-monthly timetabled basis by 31.1 18 Plan to publish complaints and learning outcomes to PPG for onward cascade to patients on a regular basis		31.01.2018 31.08.2017 31.01.2018
Delivery of safe and effective care				
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	2.1 Managing risk and promoting health and safety	H&S policy to be reviewed for adoption by 31.7.17 Specifics:- DSE - all workstations/staff to have DSE risk assessments. Ongoing according to phase of the refurbishment. Spreadsheet to demonstrate current status updated by 31.1.18	Interim PM / Project Manager / All Staff	31.07.2017 31.01.2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
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. The practice must ensure that all health and safety risks associated with the refurbishment work have been formally considered and assessed so that patient safety is protected during this time. The practice must ensure that a fire risk assessment, carried out by an appropriately competent professional, is completed as soon as possible in order to inform the planned period of refurbishment work. Fire risk assessments should be kept up to date, monitored, with actions implemented to minimise risks within the environment on an ongoing basis.		COSHH - policy review and updated by 30.9.17 Legionella RA - completed. Asbestos survey - completed. Training issue for staff: H&S update to be timetabled by 30.9 17 Liaise with Cleaners - review and update cleaning schedules with specific regard to COSHH, Waste management and confidentiality by 30.9.17 Fire RA undertaken by Rob Roome, Fire Safety Services on 26.5.17 Action points identified for completion by 31.10.17 policy review staff training update Re-introduce regular fire drills (to be documented and recorded) Repeat FIRE RA (booked for January 2018 -on completion of the refurbishment of the premises)		30.09.2017 30.09.2017 30.09.2017 26.05.2017 31.10.2017

Improvement needed	Standard	Service action	Responsible officer	Timescale
Staff must review the security arrangements for the storage of the clinical waste bin in the car park to ensure this is sufficiently secure. The infection control policy requires review to ensure it accurately reflects current working practices. Staff should be trained in infection control policy and procedures and evidence of this should be recorded. Staff must ensure that they can demonstrate how infection control risks within the environment are assessed, monitored and actions take to address these risks, e.g. through infection control audits.	2.4 Infection Prevention and Control (IPC) and Decontamination	Relocation planned to secure area of car park on completion of refurbishment work (NB it is not possible to undertake this earlier due to presence of builders equipment and vehicles). In the interim the bins are locked and secure at the rear of the premises. 31.1.18 IPC baseline audit due and booked with. AP and LY (TGS IPC Lead) on completion of nurses treatment rooms upgrade. RA and action points to be addressed prn but by 31.10.17 An update will be required on completion of the project January 2018 Training: IPC updates planned for all staff at appropriate levels using e-learning for health or Bluestream by 30.11.2017	Projection Manager / Interim PM Interim PM / Clinical Lead	31.01.2018 31.10.2017 30.11.2017
The practice must ensure there is a POVA	2.7 Safeguarding	Policy updates and training reviews to	Interim PM	30.11.2017

Improvement needed	Standard	Service action	Responsible officer	Timescale
policy in place that meets all Wales guidance and that all staff are aware of the policy and how it informs their working practices. The practice must ensure that all staff receive up to date child protection and vulnerable adults training at a level appropriate to their role.	children and adults at risk	be completed by 30.11.17 (recent MDU training took place at TGS on 13.6.17 for clinical staff). Training schedule and matrix in development for all mandatory training by 31.10.17.		
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 acute conditions/minor illnesses to ensure medications are appropriately linked to records Recording when patients are provided with written information Review of storage of patient paper records to ensure the practice is compliant with data protection legislation. The practice must ensure that all patient identifiable information is stored securely in line with the Data Protection Act 1998. Specifically, patient identifiable	3.5 Record keeping	Policies are under review. New staff are being recruited and appropriate training organised for 8.8.17 (on Vision, Workflow and Scanning and Read Codes) to ensure the highest standards of record keeping are maintained in accordance with practice protocols. Accordingly staff are required to document all pt encounters to MR. On the wall document holders have been removed.	Interim PM	8.8.17

Improvement needed	Standard	Service action	Responsible officer	Timescale
information must not be stored in open drops outside consultation/treatment rooms.				
Quality of management and leadership				
The practice should ensure that policies are easy to access, updated, and communicated to staff on an ongoing basis	Governance, Leadership and Accountability	Policies and procedures are under review by the new management team with reference to Health Board guidelines and FPM. These will be published alphabetically on the practice's G-drive for easy access. Training will be provided to all staff with demonstrations/testing on access. This will become a regular agenda item at Team meetings. Updates to policies will be undertaken annually (or sooner if legislation/policies change) and cascaded to staff. Reference to P&Ps will be included in annual staff appraisals. Initial review of policies to be completed by 31.10.17	Interim PM	31.10.2017

Improvement needed	Standard	Service action	Responsible officer	Timescale
Practice management staff must be able to identify staff training needs. The practice must ensure they can demonstrate how staff are supported to stay up to date with ongoing training requirements.	7.1 Workforce	A priority for the new management team is the accurate recording of training. We have commenced work on a training matrix for mandatory training. We aim to introduce formal training plans for all staff groups and document training undertaken. Access to previous training records is intermittent. Training policy and matrix will be in place at the latest by 31.12.17 together with records of training undertaken in the intervening period. We will engage with e-learning for Health and/or Bluestream/MDU/other providers to ensure that all staff are up to date with training personal development plans. The management team will monitor staff compliance with training objectives and report regularly to the Partners.	Interim PM	31.12.2017

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): SM Lapping

Job role: Acting Practice Manager

Date: 21.06.2017