Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection (Announced)

Six Bells Medical Centre / 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 Six Bells Medical Centre, Eastville Road, Six Bells, Abertillery, NP13 2PB within Aneurin Bevan University Health Board on the 23 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, improvements were required at Six Bells Medical Centre to ensure that systems were sufficiently robust to provide consistently safe and effective care. We found a hard working, committed staff team. However, we found evidence that the practice was not fully compliant with a number of Health and Care Standards.

This is what we found the service did well:

- Patients gave positive feedback about staff and the care provided
- Overall the standard of record keeping was good, with practice nurse records in particular being of an excellent quality
- We found a patient-centred, committed and hard working staff team.

This is what we recommend the service could improve:

- Patients were less satisfied with waiting times, the environment and having to see several different doctors
- Attention was required across a number of areas to ensure internal systems were sufficiently robust
- The practice was currently under a great deal of pressure in meeting patient demand due to lack of GP resource and challenges in securing locum GPs
- Several aspects within the practice required improvement to ensure patients' privacy and confidentiality was suitably maintained
- Staff awareness of, and the practice's compliance with, health and safety law, policy and risk assessment duties required improvements
- A number of aspects of the patient experience required improvements including; staff requiring chaperone training, maintaining patient privacy, complaints information/records and the accessibility of patient information
- A number of aspects of workforce management required improvements including; ensuring staff had undergone appropriate

checks, ensuring staff received training in mandatory areas, improving locum information and carrying out staff appraisals.

3. What we found

Background of the service

Six Bells Medical Centre currently provides services to approximately 5,203 patients in the Abertillery 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 one GP, two nurses, four receptionists, one part time practice manager and one deputy practice manager.

There is one branch surgery at the Medical Centre, Institute House, Llanhilleth Institute, Llanhilleth, Abertillery, NP13 2JH.

The practice provides a range of services.

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 mixed. Patients made positive comments about staff and the care provided. Patients were less satisfied with waiting times, having to see several different doctors and the environment.

We found people were treated with dignity and respect. Staff required chaperone training.

Information was available to support patients to stay healthy. 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. Patients must be offered access to interpreting services.

There was a need to review aspects of the internal communication and organisational systems to ensure systems were sufficiently robust.

Although patients were not satisfied with the appointments system, we saw that patients were seen according to urgency. The practice was under significant pressure in meeting demand due to the lack of permanent GP resource.

The practice had a system in place to enable patients to raise concerns/complaints but records were not being kept and complaints information was not easily accessible. There were no mechanisms in place to allow patients to provide feedback.

During our inspection we distributed HIW questionnaires to patients to obtain their views on the service provided at the practice. A total of five questionnaires were completed. These ranged from patients who had been at the practice for less than a year, to patients who had been at the practice for more than two

years. We also spoke informally with patients to obtain their views. Overall, patient feedback was mixed. Patient comments included the following:

> *"Helpful staff"*
>
> *"Turned up at 11:40 for a 11:50 appointment, still waiting at 12:30"*
>
> *"Lots of clutter. Worn down practice"*
>
> *“More doctors with more time to spend with you” (suggestion given by a patient about how they felt the service could be improved)*

Staying healthy

There was information available to help patients to take responsibility for their own health and information for carers.

There was a range of health promotional materials available for patients, provided through leaflets and posters in the waiting area. This meant that patients could access information to support them in taking responsibility for their own health and wellbeing.

One of the practice nurses told us about the links they had developed with Blaenau Gwent Health and Lifestyle Team and how they introduced this service into patient reviews, to support patients with healthy lifestyle choices. We identified this as an area of noteworthy practice.

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

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. We saw staff going out to patients in the waiting area to assist where needed.

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 a certain extent to support this. For example, the reception area was in a separate room to the waiting area and reception staff used a hatch with shutters, between the rooms, to address patients. This meant that the reception space was shielded from view. Staff could attend to patients using wheelchairs by leaning over the desk or through the door to the waiting area. Staff also told us that they could use other areas of the practice, for example, an empty consultation room to discuss any sensitive issues with patients to maintain confidentiality.

However, despite the measures taken, we found that conversations taking place in the reception area (for example, between receptionists and patients on the telephone) could be overheard in the waiting area, due to the physical layout and soundproofing of the building (even when shutters were closed). The lack of space and physical layout of the waiting area also meant that it was possible to hear patient conversations with receptionists easily, when approaching the hatch. Staff must consider how to protect patient privacy in this regard.

There was a notice in the waiting area displaying patients' rights to request a chaperone. There was a lack of a chaperone policy in place. Staff told us that both clinical and non-clinical staff acted as chaperones. Non-clinical staff had not received any training on acting in this role.

Improvement needed

The practice must ensure that patient confidentiality and privacy is protected at all times. Specifically, measures must be put in place to prevent patient identifiable information being overheard by other patients.

A chaperone policy must be put in place and non clinical staff acting as chaperones must receive training to enable them to understand the role and responsibilities it entails.

Patient information

Information for patients about the practice's services was available within a practice leaflet. However, this required updating and was not made readily available for patients attending the practice. Some practice information was displayed in waiting areas including opening times, the process for obtaining repeat prescriptions and out of hours information. All patients who completed a questionnaire stated that they would know how to access the out of hours GP service. We saw that information displaying doctors' names outside the practice required updating. There was currently no practice website. This meant overall that up to date information about the practice was not easily accessible to the practice population.

Staff told us they did not produce information in other languages or formats. There was a lack of information available in Welsh. 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 other accessible formats.

Improvement needed

The practice must ensure that the practice information leaflet provides full, comprehensive, up to date information.

The signage outside the practice requires updating to ensure correct doctors' details are displayed.

The practice must consider how to make information about the practice easily accessible to its practice population.

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 were not aware of how to access interpreting services for those patients whose first language was not English and told us they relied on family members for this part of their practice population. The use of family members may not always be appropriate and therefore the practice must ensure they offer interpreting services to their patients. 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.

The practice had a hearing loop, however staff told us this was not used and they did not know how to use it. Staff should be fully trained on using this so that they are able to offer this service to enhance communication with patients who have hearing difficulties.

We saw that a dual system was used to call patients into appointments which included a screen system and a buzzer. The call system used by the doctors did not display patient names when the buzzer sounded. This led to confusion amongst patients regarding who was due to go in next. Although patients did not miss appointments as a result, this led to delays with staff having to come out into the waiting area and prompt patients.

We also saw that some patients were not aware of having to knock on the hatch when this was closed, to get the attention of receptionists to book themselves in for their appointments. Although there was a sign on the hatch, this was not clear, particularly for those patients who may have visual impairments.

Patients were asked on the questionnaire whether they were asked questions about their medical problem when they try to make an appointment; there was a mixed response to this question, with some patients answering yes, and some patients answering no. Most of the patients who answered yes said that they understood why they were asked questions about their medical problem when they try to make an appointment.

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 information about out of hours consultations.

However, we found that some aspects of internal communication systems required improvement to ensure they were sufficiently robust:

- There was no follow up system in place to ensure that once correspondence is passed onto the GP, that this is actioned
- Lack of a formal and agreed process in place for ensuring that when an incoming result requires follow up, this is actioned by the appropriate staff member (the GP took responsibility for following up all results which was a considerable task, due to the number of locum doctors used)

- Use of paper messages instead of electronic meant that there was a greater risk of information going missing and lack of an appropriate audit trail.

- There was a system for recording patient deaths. However, staff were not aware of a process being in place to alert out of hours services to patients dying at home, to ensure the care and treatment provided to these patients was in accordance with any agreed plan of care. There was not a system in place for informing all relevant team members involved when patients were admitted into hospital as an emergency.

We reviewed five discharge summaries and we saw that these were variable in quality. There was a system for ensuring these were recorded onto patient records with the GP taking responsibility for this.

Improvement needed

The practice must have a formal arrangement in place to access interpreting services. Interpreting services must be offered to patients who may require it.

Staff must be trained on the use of the hearing loop and this service must be offered to those patients who may require it.

The practice must review use of the dual system for calling patients into appointments to ensure there is a system in place that is accessible for all patients, including those with hearing difficulties.

The practice must ensure that the system for patients to knock on the hatch to let receptionists know they are there is made clear and communicated to patients. Those patients with additional needs must also be considered.

The following aspects of the internal communications systems must be reviewed to ensure safe practices are in place which are sufficiently robust:

- There was no follow up system in place to ensure that once correspondence is passed onto the GP, that this is actioned

- Lack of a formal and agreed process in place for ensuring that when an incoming result requires follow up, this is actioned by the appropriate staff member (the GP took responsibility for following up all results)

- Use of paper messages instead of electronic meant that there was a greater risk of information going missing and lack of appropriate audit trail.

- There must be a process in place to alert out of hours services to patients dying at home.
- There must be a process in place for informing all relevant team members involved when patients were admitted into hospital as an emergency.

Timely care

All of the patients who completed a questionnaire said that they were very satisfied with the hours that the practice was open.

Patients were able to book appointments in person and by telephone. The majority of patients who completed a questionnaire felt that it was not very easy to get an appointment when they needed it. All patients described their experience of making an appointment as either poor or very poor. Staff told us that the appointments system now ran using GP triage; this meant that a doctor would consider and prioritise patients' needs for an appointment. We saw that patients could book urgent appointments on the same/next day and routine appointments were available in advance. We saw receptionists booking both urgent and routine appointments for those patients requiring them on the day of the inspection, by telephone and in person. Staff told us that they would always try to accommodate anyone who had an urgent need for an appointment on the same day. Our review of patient records confirmed this.

Patients indicated that they sometimes experienced long delays in waiting to see the doctor on attendance at the surgery for their appointments. We witnessed this on the day of our inspection. When asked by patients, staff were forthcoming with information about there being a wait. However, the practice should consider how to reduce waiting times and how to communicate effectively and proactively with patients about delays.

The nursing team 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.

There was not currently a referral policy or protocol in place to guide staff in making referrals and due to the high usage of locum doctors, each doctor used their own clinical judgement in making referrals. This meant there was also a lack of an agreed standard timescale for completing 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 should consider how to reduce waiting times and how to communicate effectively and proactively with patients about delays.

The practice must ensure there are agreed protocols regarding referrals. 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 found that patients, who required them, were offered regular personal health checks, including vulnerable patients and those with additional needs, for example, patients with mental health difficulties. We saw minutes from a recent palliative care meeting which demonstrated that a multi-disciplinary approach was taken in planning care and treatment for these patients.

We saw that those patients with additional needs were flagged on the electronic system as a way to alert staff so that suitable arrangements could be made when booking appointments.

Staff knew their patients well and confirmed that they offered longer appointments to patients where required, in order to meet their individual needs.

People’s rights

People's rights in terms of accessible information and communicating in a language of their choice require improvement and have been addressed above.

We saw that patients' rights regarding data collection were explained in a leaflet which was available in the waiting area. Staff told us they signed confidentiality agreements on starting employment at the practice but these records were not available for us to view. Staff were aware of their responsibilities in the handling of sensitive information.

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 the Community Health Council (CHC) as an advocacy service with making complaints.

All patients who completed a questionnaire said that they 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 waiting area apart from some generic 'Putting Things Right' leaflets and a written notice giving limited information. Complaints information was not available to patients through any other means.

We saw that records of complaints had been maintained until November 2016 but were no longer maintained. We were therefore unable to establish whether complaints were being appropriately managed and within specified timescales. Records of complaints must be kept.

There was a lack of any kind of system to allow patients and carers to provide feedback on services.

Improvement needed

The practice must ensure it keeps records of complaints. Patient complaints must be managed in line with Putting Things Right guidelines and within specified timescales.

The practice must ensure there are systems in place to empower patients and carers to provide feedback on services. The practice must be able to demonstrate how feedback is used to improve services.

Delivery of safe and effective care

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

Attention was required across a number of areas to ensure internal systems were sufficiently robust.

We have asked the practice to make improvements to health and safety and risk management across a number of areas. This includes ensuring there is an up to date fire risk assessment in place.

We found suitable infection control arrangements in place. Attention was needed 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.

Improvements were needed to the system of prescribing medicines to ensure systems were sufficiently robust.

Child and adult protection policies were required and we could not be assured that staff had completed up to date training in these areas.

Improvements were needed to ensure appropriate recording of significant events and adverse reactions to drugs took place.

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

Safe care

Managing risk and promoting health and safety

All patients who completed a questionnaire felt it was easy to get into the building that the GP practice is in. There was an accessible environment with ramp access into the practice. We saw that the auto-door mechanism (which allowed doors to be opened at the push of a button) was not currently working

and we advised the practice to repair this to ensure the environment was fully accessible, particularly for those patients using wheelchairs. We saw that all patient services were provided on the ground floor which meant that patients did not have to negotiate stairs once inside the building. Disabled toilet facilities were available. There was clear signage to direct patients.

There were some areas within the practice where repairs were required. This included the lighting of the corridor leading from the waiting area to consultation and treatment rooms, and the light fitting in the reception area. The practice manager agreed to organise the repair of these. During our inspection some maintenance work was taking place on the telephone system which meant that work was being carried out in patient areas. At times some stock was left in patient areas which increased risks of trips and falls. There was a lack of coordination of this work or consideration of the increased potential health and safety risks to patients and this should be considered in the future to minimise patient impact.

The practice manager advised us that health and safety was not an area they had focussed on since coming into post, due to the pressing demands of staffing and meeting patient demand. We found two health and safety policies, and some guidelines covering aspects of health and safety. However, policies gave conflicting information, did not cover all mandatory areas and were not being used as live documents to guide staff in their working practices. A policy covering all mandatory areas is required to ensure all staff are aware of, and fulfilling, their duties regarding health and safety law. 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 found that a fire risk assessment was not in place, as required under health and safety regulations. This was at a time when some staff areas of the practice were being used to store furniture and patient records that had been sent over from the merged practice. This meant we could not be assured that fire risks had been fully considered to maintain patient and staff safety within the practice environment, at a time when risks were higher. Our concerns regarding this 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.

We saw that fire safety equipment had been checked and serviced. There was a fire logbook in place showing that all required in-house checks had taken place up to 2015. Following this, staff were using a lined book to record weekly fire alarm checks only. There was a requirement for the full programme of checks advised under fire regulations to recommence. The practice must take advice around this to ensure they comply with fire safety legislation.

The practice manager advised that managing and reporting risks within the practice happened informally, with staff reporting these to management. There was a lack of formalised assessments or plans to support business continuity and risk management.

There were emergency equipment and emergency drugs at the practice to manage medical emergencies. Staff had completed and were up to date with cardiopulmonary resuscitation (CPR) training.

Improvement needed

The practice should repair the auto-door mechanism to ensure entry is fully accessible to all.

Repairs are required to the lighting in the corridor leading from the waiting area to the treatment/consultation rooms and the light fitting in the waiting area.

Staff must ensure that when any maintenance work is planned, and the practice remains open to patients, health and safety has been considered and measures are taken to protect the safety and reduce the impact on patients.

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).

An environmental health and safety risk assessment must be carried out; monitored and updated on an ongoing basis, to ensure that all risks within the practice environment have been identified, considered and actions taken to reduce risks.

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

All required in-house fire equipment checks must recommence and be recorded in line with fire safety regulations.

A business continuity plan must be put in place, which contains up to date information around how disasters and/or emergencies will be managed. All staff should be made aware of this plan.

Infection prevention and control

Patients completing questionnaires raised some concerns over the cleanliness of the GP practice. However, we found the practice environment to be 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.

There was a detailed infection control policy in place. 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 register in place to record this but it had not been updated to reflect the current immunisation status for all staff.

Improvement needed

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.

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 arrangements for the safe prescribing of medicines to patients required review, to ensure systems were suitably robust.

There was a health board pharmacist who provided support to the practice on an adhoc basis. The practice used the health board's formulary[1].

Staff told us that there was no formal system in place to ensure that medicines that were no longer needed, were removed from the repeat prescribing list. Medicines were removed by the GP on an adhoc basis, for example, following a hospital discharge letter or during a consultation with a patient. Due to the lack of GP resources this meant that one GP took sole responsibility for this task.

We saw that prescribing errors were captured in patient notes. Management staff gave conflicting information around whether incidents were recorded and reported as significant events. Staff were not able to produce records. We could

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

therefore not be assured that appropriate reporting was taking place or that any learning from these incidents was being shared.

Staff told us that concerns about adverse reactions to drugs were not currently reported, except within patient records.

Improvement needed

Staff must ensure there is a system in place to remove medicines that are no longer needed from the repeat prescribing list.

Staff must report prescribing errors as significant events and must report adverse reactions to drugs in line with national guidelines.

Safeguarding children and adults at risk

Staff had access to national child protection guidelines to guide their practice. However there was a lack of a child protection policy for the practice in place. A policy around the protection of vulnerable adults (POVA) policy was not in place and is also required.

Management staff were not able to confirm what training staff had completed and most staff we spoke with could not remember completing safeguarding training. Therefore, we could not be assured that all staff were sufficiently trained to identify and manage child and adult protection issues. The nurse was able to confirm they had completed safeguarding training to level two.

We looked at the process in place for flagging safeguarding cases on the electronic system and we found these to be appropriate.

We could not be assured that multi-disciplinary working took place around child and adult safeguarding as there was a lack of evidence demonstrating that systems such as regular meetings, to share information and discuss cases, were held.

Improvement needed

The practice must ensure there are POVA and child protection policies in place that meet all Wales guidance and that all staff are aware of these policies, their roles and responsibilities, and how policies inform 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. This includes all staff, with clinicians now required to receive safeguarding training up to level

three.

The practice must ensure that it is able to demonstrate that it supports and plays an active role in multi-disciplinary working and sharing of information around child and adult safeguarding concerns.

Effective care

Safe and clinically effective care

Management staff gave conflicting information about whether there was a system in place to report patient safety incidents and significant events. Staff were unable to show us any records of these. We could therefore not be assured that issues or events of concern were being appropriately reported as significant events.

Staff told us that due to pressures, any meetings to review incidents or events were opportunistic and adhoc and there wasn't currently a system for disseminating any learning to the wider staff team.

There was a system in place for clinicians to be made aware of patient safety alerts 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.

Improvement needed

The practice must ensure that they report all patient incidents and significant events appropriately. A culture of learning around incidents should be encouraged and promoted.

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 and 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. It was positive to see that all locum doctors had their own log in details which meant there was a clear audit trail in tracking entries back to individuals. However, we found that the set of initials in some clinical

entries did not always match the set of initials on the consultation screen. This meant that it was not always clear from the records who was responsible for the consultation and the practice should resolve this as soon as possible.

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. We found in some cases that problem lists required updating to ensure only current issues were listed.

Overall, notes contained good 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. Notes made by practice nurses were of a particularly high quality.

There was good practice in the Read coding[2] of patient records. We found the notes made by practice nurses in chronic disease management consultations to be excellent, which gave consistency to both the quality of records and coding over time. We advised that Read coding by doctors for clinical observations could be used more, to further improve this area.

In the patient records we reviewed there was clear recording around the reasons for initiating and discontinuing medicines and long term medication was almost always linked to medical conditions.

There was little evidence of information being offered to patients or notes to indicate that discussions about patients' care and treatment took place. Staff assured us that they did this but did not always record it and we advised to record when this was done.

We found that the storage of records required review to ensure sufficient security and protection of patient confidentiality. We found bags containing patient information ready for shredding were being stored in the patient waiting area. Not all bags were sealed and patient identifiable information was visible through the bags. Our concerns regarding this were dealt with under our

[2] Read Codes were developed by Dr. James Read. The UK National Health Service Centre for Coding and Classification (NHS CCC) acquired and now maintains the Read Codes. Read Codes are a standard terminology for describing the care and treatment of patients.

immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B. We also found that some patient records (which had been moved over from the merged practice), were currently being stored unlocked, in an office that was unlocked throughout our inspection. Staff told us the office was normally locked. Staff must ensure that all patient identifiable information is protected in line with the Data Protection Act 1998 on an ongoing basis.

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 a tray containing patient documents and correspondence that dated back one year. Staff were not aware of the documents being in the tray and were unclear if the correspondence had been seen/actioned. Our concerns regarding this were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

Improvement needed

The practice should investigate the reason for staff initials in some clinical entries not always matching the set of initials on the consultation screen and should resolve this as soon as possible.

Staff must record the ways in which patients are involved in decisions relating to their treatment, including the provision of any written information.

The practice must ensure that all patient identifiable information is stored securely in line with the Data Protection Act 1998. Specifically, patient identifiable information should be stored securely, with patient confidentiality maintained, prior to shredding. In addition, all patients' records must be appropriately locked and kept securely.

The practice must review all patient documents in the tray found by the inspection team and ensure that any appropriate actions have been taken.

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 with the reduction of GP partners from three to one and the absorption of approximately 2,000 new patients. There was a reliance on locum GPs which were not always able to be secured and challenges in recruiting permanent GPs to this area. This meant that staff and the service were currently under extreme pressure in terms of meeting patient demand. There was part time practice management support.

Staff were focussed on the most pressing demands and priorities. However, given the number of improvements identified in this report, there was a need for other key areas of practice management to be given focus and attention to ensure the safe and effective running of the practice.

We found a patient-centred, committed and dedicated frontline staff team who told us they felt supported. There were a number of areas regarding workforce management which required improvements including; ensuring staff had undergone appropriate checks, ensuring staff received training in mandatory areas, improving locum information and carrying out staff appraisals.

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. Over the last two years, the number of GPs had reduced

from three to one. The practice had taken on approximately 2,000 additional patients and for a time had been supported by the Primary Care Operations Support Team within the health board. This support was in place for around six months following the absorption of the extra patients. When the PCOST Team withdrew, the practice team employed a part time practice manager (in October 2016) to support the remaining GP with the day to day management of the practice.

The practice manager and GP described the considerable challenges they were facing in ensuring the practice was able to meet patient demand. There were extreme challenges in recruiting GPs within the area and the practice relied heavily on locum GPs. However, at times, there were difficulties even in securing locums. This meant that the one GP was absorbing all the additional work, which was not sustainable on an ongoing basis.

The practice manager advised that their role was primarily a pastoral role for staff and they were concerned primarily with staffing and ensuring services could continue to run. Given the number of improvements we have identified as required at the practice, there was a clear need for additional management support to address other important practice management issues and areas.

We found a staff team who were committed to providing the best services possible to their patients and demonstrated a willingness and commitment to working hard and supporting each other to ensure the practice could keep running. 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.

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

The practice had some relevant written policies and procedures to guide staff in their day to day work. However, we found an absence of some key policies, some duplication and staff were not always clear regarding which one governed their working practices. Management staff were not able to clarify where to find policies, which policies were currently in use and were not updating policies or regularly communicating them to staff.

Some staff working within the practice 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.

Staff told us they met informally to discuss practice issues and patient care and treatment. Due to the demands on the service, practice meetings were no

longer taking place. There was also a lack of a formal meeting/forum in which to discuss clinical cases. As a result there was a lack of evidence of the discussion of clinical areas and/or sharing of learning from incidents or best practice, relating to patient care. Methods of communication should be reinstated to support the running of the practice and learning around patient care and treatment.

Management staff told us there was not currently a Practice Development Plan in place, due to demands on the service. The practice was not currently engaging in future planning due to their focus on sustaining the service in the context of the current challenges they were facing. Staff were acutely aware of their immediate priorities and were working hard to meet these.

The GP told us they attended the NCN[3] meetings and used this forum as a way to keep up to date with local developments and share practice. There was currently a lack of peer review, also due to pressures involved in meeting patient demand and reliance on locum GPs. Given the improvements we have identified across a number of areas, we advise the practice to consider how to encourage improvement activities, peer review and shared learning where this is possible.

Improvement needed

There must be sufficient management time allocated to attend to all areas of practice management and to address improvements across all areas.

Staff must continue with their efforts to recruit GPs to the practice; to reduce the use of locums and to release pressure from the one remaining partner.

The practice must consider how they promote communication, improvement activities, peer review and shared learning.

Staff and resources

[3] 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

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. We found that annual appraisals were not happening and management staff did not believe that these were helpful as a working practice. Yearly appraisals must be carried out to give staff the opportunity to receive feedback on their performance, to discuss training needs and indicate if any additional support is needed.

Management staff were not able to locate Human Resources (HR) and recruitment documentation. We were able to find an employment policies and procedures manual but this required updating. Management staff were not able to give assurance that appropriate checks had been or were carried out prior to employment as they did not know where to access historic records. One staff member was able to confirm they had been subject to a DBS check prior to employment, however, was not able to confirm any other checks.

There was a lack of a formal process in place to induct new members of staff. There was no locum GP pack in place to support locum GPs working at the practice.

Staff we spoke with confirmed they had opportunities to attend relevant training. However, 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 and management staff told us this was not a priority currently. This required attention to ensure that staff completed all mandatory topics as soon as possible.

Improvement needed

All staff must receive annual appraisals.

Relevant checks for all new members of staff must be carried out and recorded. Practice management staff must review the records for staff currently working at the practice and provide HIW with assurance that all relevant checks have been carried out. Where there is any doubt, new checks must be carried out.

The practice must ensure that induction processes are in place. There must be

a locum GP pack in place which provides comprehensive, useful information about the practice to help guide locum GPs.

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. Staff must ensure that mandatory training is completed in a timely way.

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: Six Bells Medical Centre

Date of inspection: 23 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 – Fire risk assessment: We found that a fire risk assessment was not in place, as required under health and safety regulations. This meant we could not be assured that fire risks had been fully considered to maintain patient and staff safety within the practice environment. Risks were presently higher due to a large volume of furniture (from a practice that had merged with Six Bells Medical Centre), being stored in upstairs areas. Improvement needed:	Health and Care Standards 2015 - 2.1 Managing Risk and Promoting Health and Safety	An interim fire risk assessment has been undertaken. Blackwood Fire & Security have been engaged to provide a risk assessment on the 8th June 2017.	Colin Jones	1st June 2017 and 8th June 2017

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
The practice must ensure that a fire risk assessment, carried out by an appropriately competent professional, is completed as soon as possible. Fire risk assessments should be kept up to date, monitored, with actions implemented to minimise risks within the environment on an ongoing basis.				
Finding – Storage of patient identifiable information: We found bags containing patient information ready for shredding were being stored in the patient waiting area. Not all bags were sealed and patient identifiable information was visible through the bags. 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 should be stored securely, with patient confidentiality maintained, prior to shredding.	Health and Care Standards 2015 - 3.5 Record Keeping	The bags will be collected on the 9th June by D365 an accredited confidential waste disposal company. We have checked all the bags and all the seals were sealed but a there were a few sacks were some small gaps had appeared were the seal had failed to hold. The sacks are in full view of patients and staff and we have had no reports of any tampering being attempted. We dispute the comment that patient identifiable information can be seen through the sacks but in the interests of harmony have covered the sacks with an opaque covering.	Colin Jones	9th June 2017

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
Finding – Patient records found requiring review/action: We found a tray containing patient documents and correspondence that dated back one year. Staff were not aware of the documents being in the tray and were unclear if the correspondence had been seen/actioned. Improvement needed: The practice must review all patient documents in the tray found by the inspection team and ensure that any appropriate actions have been taken.	Health and Care Standards 2015 - 3.5 Record Keeping	These records were checked by staff and were found to have been actioned on or around the date received. They were initialled by a PCOST nurse practitioner. The staff can only surmise that she had asked for them to be held back for her perusal but had left before sanctioning their disposal.	Colin Jones	Immediately

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): **COLIN JONES**

Job role: **Practice Manager**

Date: **1 June 2017**

Appendix C – Improvement plan

Service: Six Bells Medical Centre

Date of inspection: 23 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			
The practice must ensure that patient confidentiality and privacy is protected at all times. Specifically, measures must be put in place to prevent patient identifiable information being overheard by other patients. A chaperone policy must be put in place and	4.1 Dignified Care			

Improvement needed	Standard	Service action	Responsible officer	Timescale
non clinical staff acting as chaperones must receive training to enable them to understand the role and responsibilities it entails.				
The practice must ensure that the practice information leaflet provides full, comprehensive, up to date information. The signage outside the practice requires updating to ensure correct doctors' details are displayed. The practice must consider how to make information about the practice easily accessible to its practice population. 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.	4.2 Patient Information			
The practice must have a formal arrangement in place to access interpreting services. Interpreting services must be offered to patients who may require it. Staff must be trained on the use of the hearing	3.2 Communicating effectively			

Improvement needed	Standard	Service action	Responsible officer	Timescale
loop and this service must be offered to those patients who may require it. The practice must review use of the dual system for calling patients into appointments to ensure there is a system in place that is accessible for all patients, including those with hearing difficulties. The practice must ensure that the system for patients to knock on the hatch to let receptionists know they are there is made clear and communicated to patients. Those patients with additional needs must also be considered. The following aspects of the internal communications systems must be reviewed to ensure safe practices are in place which are sufficiently robust: • There was no follow up system in place to ensure that once correspondence is passed onto the GP, that this is actioned				

Improvement needed	Standard	Service action	Responsible officer	Timescale
• Lack of a formal and agreed process in place for ensuring that when an incoming result requires follow up, this is actioned by the appropriate staff member (the GP took responsibility for following up all results) • Use of paper messages instead of electronic meant that there was a greater risk of information going missing and lack of appropriate audit trail. • There must be a process in place to alert out of hours services to patients dying at home. There must be a process in place for informing all relevant team members involved when patients were admitted into hospital as an emergency.				
The practice should consider how to reduce waiting times and how to communicate effectively and proactively with patients about	5.1 Timely access			

Improvement needed	Standard	Service action	Responsible officer	Timescale
delays. The practice must ensure there are agreed protocols regarding referrals. 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.				
The practice must ensure it keeps records of complaints. Patient complaints must be managed in line with Putting Things Right guidelines and within specified timescales. The practice must ensure there are systems in place to empower patients and carers to provide feedback on services. The practice must be able to demonstrate how feedback is used to improve services.	6.3 Listening and Learning from feedback			

Improvement needed	Standard	Service action	Responsible officer	Timescale
Delivery of safe and effective care				
The practice should repair the auto-door mechanism to ensure entry is fully accessible to all. Repairs are required to the lighting in the corridor leading from the waiting area to the treatment/consultation rooms and the light fitting in the waiting area. Staff must ensure that when any maintenance work is planned, and the practice remains open to patients, health and safety has been considered and measures are taken to protect the safety and reduce the impact on patients. 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	2.1 Managing risk and promoting health and safety			

Improvement needed	Standard	Service action	Responsible officer	Timescale
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). An environmental health and safety risk assessment must be carried out; monitored and updated on an ongoing basis, to ensure that all risks within the practice environment have been identified, considered and actions taken to reduce risks. Fire risk assessments should be kept up to date, monitored, with actions implemented to minimise risks within the environment on an ongoing basis. All required in-house fire equipment checks must recommence and be recorded in line with fire safety regulations. A business continuity plan must be put in place,				

Improvement needed	Standard	Service action	Responsible officer	Timescale
which contains up to date information around how disasters and/or emergencies will be managed. All staff should be made aware of this plan.				
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. 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			
Staff must ensure there is a system in place to remove medicines that are no longer needed from the repeat prescribing list.	2.6 Medicines Management			

Improvement needed	Standard	Service action	Responsible officer	Timescale
Staff must report prescribing errors as significant events and must report adverse reactions to drugs in line with national guidelines.				
The practice must ensure there are POVA and child protection policies in place that meet all Wales guidance and that all staff are aware of these policies, their roles and responsibilities, and how policies inform 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. This includes all staff, with clinicians now required to receive safeguarding training up to level three. The practice must ensure that it is able to demonstrate that it supports and plays an active role in multi-disciplinary working and sharing of information around child and adult safeguarding concerns.	2.7 Safeguarding children and adults at risk			
The practice must ensure that they report all patient incidents and significant events appropriately. A culture of learning around	3.1 Safe and Clinically Effective			

Improvement needed	Standard	Service action	Responsible officer	Timescale
incidents should be encouraged and promoted.	care			
The practice should investigate the reason for staff initials in some clinical entries not always matching the set of initials on the consultation screen and should resolve this as soon as possible. Staff must record the ways in which patients are involved in decisions relating to their treatment, including the provision of any written information. The practice must ensure that all patient identifiable information is stored securely in line with the Data Protection Act 1998. All patients' records must be appropriately locked and kept securely.	3.5 Record keeping			
Quality of management and leadership				
There must be sufficient management time allocated to attend to all areas of practice management and to address improvements	Governance, Leadership and Accountability			

Improvement needed	Standard	Service action	Responsible officer	Timescale
across all areas. Staff must continue with their efforts to recruit GPs to the practice; to reduce the use of locums and to release pressure from the one remaining partner. The practice must consider how they promote communication, improvement activities, peer review and shared learning.				
All staff must receive annual appraisals. Relevant checks for all new members of staff must be carried out and recorded. Practice management staff must review the records for staff currently working at the practice and provide HIW with assurance that all relevant checks have been carried out. Where there is any doubt, new checks must be carried out. The practice must ensure that induction processes are in place. There must be a locum GP pack in place which provides comprehensive, useful information about the	7.1 Workforce			

Improvement needed	Standard	Service action	Responsible officer	Timescale
practice to help guide locum GPs. 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. Staff must ensure that mandatory training is completed in a timely way.				

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):

Job role:

Date: