Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection (Announced)

Alfred Street Primary Care Centre, Abertawe Bro Morgannwg 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 receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

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 Alfred Street Primary Care Centre at 12-14 Alfred Street, Neath, SA11 1EF, within Abertawe Bro Morgannwg University Health Board on the 21 January 2019.

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 that staff within the practice were happy within their roles, telling us that they felt supported by the GP partners and the senior team. In addition, patient comments regarding the staff and the service provided were generally positive.

We found that the practice was not always equipped to provide safe and effective care to patients. This was because there was minimal resuscitation equipment available and we did not see evidence that all staff were appropriately trained to undertake or provide specific aspects of care. Therefore, we found that the practice was not fully compliant with the Health and Care Standards in all areas of service provision.

This is what we found the service did well:

- Patients made positive comments about the service they had received from the practice, and patients could receive timely care
- We saw that staff were polite, courteous and professional to patients and visitors at the practice
- The practice was visibly well maintained, clean and uncluttered
- Staff said that they were happy in their roles, that the senior team and GP partners were supportive and that leadership within the practice was good,

This is what we recommend the service could improve:

- The practice website requires updating, along with the practice patient information leaflet, to reflect the current service provision, and to contain all relevant practice information
- Written policies and procedures should be reviewed and updated to ensure they all accurately reflect current arrangements at the practice
- The practice should ensure all staff have received up to date mandatory training and that records for this are maintained and available.

Our concerns regarding the availability of resuscitation equipment and resuscitation update training, were dealt with under our immediate assurance process. This meant that we wrote to the practice immediately following the inspection, requesting that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in Appendix B.

3. What we found

Background of the service

Alfred Street Primary Care Centre currently provides services to approximately 2500 patients in the Neath area. The practice forms part of GP services provided within the area served by Abertawe Bro Morgannwg University Health Board.

The practice employs a staff team which includes four GP partners, one practice nurse, one Health Care Support Worker (HCSW), a deputy practice manager and a team of administrative staff. The senior practice manager covers all three practices under the Rosedale Medical Group in Neath Port Talbot.

There are also other clinical support services available, that were provided by professionals employed by Abertawe Bro Morgannwg University Health Board. These included district nurses, health visitors, midwives and a pharmacy technician.

The practice provides a range of services, including:

- General medical services
- Minor surgery
- Baby & child clinic
- Blood pressure and heart disease risk assessment
- Asthma clinic & diabetic clinics
- Family planning & smear tests
- Travel advice and immunisation
- Dressings & removal of stitches
- Phlebotomy (taking blood for laboratory tests)
- Non NHS services (for example completing insurance claim forms).

For ease, Alfred Street Primary Care Centre will be referred to as The Practice, throughout the report.

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.

Patients generally provided positive comments about the staff team and the services provided at the practice. We saw that efforts were made to protect patients' privacy and dignity, and that the services offered by the practice were accessible to patients and provided in a timely manner. However, the practice website requires updating along with the practice patient information leaflet, to accurately reflect the current service provision, and to contain all relevant practice information.

Prior to the inspection, we invited the practice to distribute HIW questionnaires to patients to obtain views on the services provided. On the day of the inspection we also spoke to patients to find out about their experiences at the practice. In total, we received 41 completed questionnaires. The majority of the patients that completed a questionnaire were long-term patients at the practice (that is, those that had been a patient for more than two years).

Patients were asked in the HIW questionnaire to rate the service provided by this GP practice. Responses were positive, and the majority of patients rated the service as either excellent or very good. Patient comments included the following:

> *"I think the GPs are doing what they do best for all their patients"*
>
> *"Until recently, reception staff were very unhelpful and very dismissive. I have had to use the surgery a lot the last two weeks with ill children, and they have been very caring and considerate in a difficult job. Niceness and politeness doesn't cost anything, as current staff show"*
>
> *"When we have needed advice and urgent prescriptions, although we could not see a doctor, a doctor spoke to us over the phone. For which we were very grateful. The*

receptionist's will always try and help solve a query or problem"

Staying healthy

Information was available on posters displayed on the walls within the waiting area and consultation rooms. This was to help patients and their carers to take responsibility for their own health and well-being. Some examples of the information displayed are:

- Smoking cessation
- Flu vaccination programme
- NHS screening services such as; bowel, breast, cervical and prostate cancer.

In addition, there were a number of health promotion leaflets available to support some of the information displayed on the noticeboards, for patients to read and to take away.

Advice and information specifically for carers was also displayed within the waiting area. The practice did not have a nominated carers' champion to help provide carers with useful information about various local agencies and organisations that may be able to support them with their day-to-day responsibilities. We advise that the practice nominates a carers' champion.

The practice offered a range of general medical services that aimed to promote patients' health and well-being. These included providing guidance on fitness to work, advice on long term medical conditions such as asthma and diabetes, travel advice, smoking cessation, and particular medications such as warfarin[1].

[1] Warfarin is a medicine that prevents blood clotting. Warfarin is often prescribed for people who have a mechanical heart valve replacement, specific irregular heart rates or have a condition caused by a blood clot such as a pulmonary embolism (a blood clot in the lungs). People taking warfarin need to have regular blood tests to ensure the dose they are taking is correct.

The practice had a Practice Development Plan (PDP) in place. Within this, there were a number of objectives and actions relating to staying healthy and health promotion. In addition, within their PDP, the practice express that they have been supportive in taking part in the All Wales Pacesetter Programme, with a hub in the Alfred Street Primary Care Centre.

For the pacesetter programme, Public Health Wales has been commissioned by the health board directors of primary care, to support the evaluation of a programme of 24 pacesetter projects, funded by the Welsh Government. The projects aim to stimulate innovation and promote the redesign of Primary Care services with pace. The 24 Pacesetter projects fall into broad themes that aim to address current challenges for primary care across Wales, and test out innovative models for delivering healthcare services.

The practice is taking part in project two, where new roles within the primary care team aim to increase capacity within the practice team, through new in-house professional roles that support the delivery of General Medical Services contracts with their local health boards, promote cluster working and enable GPs to spend more time with acutely unwell patients and those with complex conditions. Extended roles include in-house pharmacists, physiotherapists, occupational therapists, mental health support counsellors and GPs with special interests.

However, the partners suggested within their PDP that they are yet to see the increased support needed throughout the Neath area to tackle the issues of mental health with the appropriate professionals such as, mental health support counsellors in post. In addition, they also suggested that they would be in support of a community mental health hotline, to ensure a quicker point of access, to those in need.

Dignified care

Without exception, all patients who completed and returned a HIW questionnaire felt that they had been treated with respect when visiting the practice. We also observed staff treating patients with courtesy and respect. However, just under two thirds of patients who completed a questionnaire told us that they could never get to see their preferred doctor.

Consulting rooms and treatment rooms were located on the ground floor of the premises and were away from the waiting area, down a small corridor. We saw that doors to the rooms were closed during consultations. This helped protect patients' privacy and dignity when they were reviewed by the GP. However, in one of the consultation rooms, the dignity curtain could not be fully closed as

appropriate. This issue must be rectified since we were told that this is the room where cervical smear tests are undertaken. Although the door to the room could be closed, there was a risk that someone could enter the room during the procedure, or during other intimate examinations.

Practice staff confirmed that patients could have a chaperone present during their consultations. The use of chaperones aims to protect patients and healthcare staff when intimate examinations of patients are performed. We were also told that it was expected that the GPs would offer chaperones in all appropriate circumstances.

The practice had a chaperone policy, however, there was no chaperone information displayed within the waiting area or consultation rooms, to advise patients that they could request a chaperone to be present. This notice should be clearly displayed within the waiting area and inside the consultation and treatment rooms.

We were told that all staff had completed chaperone training however, there were no certificates or evidence to demonstrate this during the inspection.

Improvement needed

The practice is required to provide HIW with details of the action it will take to ensure that:

- The dignity curtain around the examination couch is replaced and others if appropriate
- All patients are aware of the availability of a chaperone if required, prior to receiving consultation or treatment
- Information for the provision of a chaperone is clearly displayed for all patients within the waiting area and consulting/ treatment rooms.

Patient information

The practice had a very basic website, which was hosted by Abertawe Bro Morgannwg University Health Board. We were told that this website was old and did not reflect the current practice and ownership. We were also told that it was developed previously when the practice was managed by the health board, and that this should be removed by the health board.

We were also told that the Rosedale Medical Group, to which Alfred Street Primary Care Centre was part of, was currently developing a new website for the Alfred Street practice. However, this is not yet available for patients.

The current website did not promote My Health Online which can assist patients in making appointments requesting repeat prescriptions. Both of these can be of benefit to patients and the practice. However, patients do not have the option of pre-booking appointments due to the use of a triage process. The triage process requires dialogue with the patient/carer, to establish a brief description of the issues. We were told that this is to direct the patient to the most appropriate service or clinician, to ensure that they receive the right care or treatment with the right clinician or service such as, physiotherapist or optician. Senior staff told us that there was a plan in place to update and improve their website.

The practice had produced an information leaflet for patients. This was not available within the waiting area but was printed and provided to us on the day of inspection. The leaflet contained minimal information about the practice and the services offered. The leaflet did not refer to the general data protection act and the security of patient data, neither was this information available on the website.

The patient information leaflet also referred to a complaints process however, it did not reference the NHS Wales Putting Things Right[2] process. In addition, there was no information on the practice website to inform patients of the complaints process.

Inside the practice, information for patients on how to raise a concern was not clearly displayed or in relation to the Putting Things Right process. In addition, there were no Putting Things Right (PTR) leaflets readily available for patients to read and take away.

We reviewed the medical records of a sample of patients. All but one patient record confirmed that verbal information had been given to patients, to help

[2] 'Putting Things Right' (PTR), is the integrated process for the raising, investigation of and learning from concerns. Concerns are issues identified from patient safety incidents, complaints and, in respect of Welsh NHS bodies, claims about services provided by a Responsible body in Wales.

them understand their medical conditions, associated investigations and management of their illness or condition. We also saw that there were suitable arrangements in place to obtain patient consent.

Whilst there was a policy in place for obtaining patient consent, this requires review and updating, and with dates and version control applied to the policy. This would ensure that all staff are using the most up to date version, which has been reviewed appropriately. The consent form used, is that provided by the local health board.

Improvement needed

The practice is required to provide HIW with details of the action it will take to ensure that:

- Formal communication is undertaken with the local health board regarding the current website, to ensure that the details they provide for the practice are removed, to prevent misinformation to patients
- The practice's patient information leaflet is reviewed to ensure that it contains relevant and useful information about the practice including the services offered, PTR complaints process and up to date general data protection regulation information
- All patients are aware of the Putting Things Right process by displaying information appropriately within the practice
- That Putting Things Right information leaflets are readily available for patients to read and take away
- The current consent policy is reviewed and updated.

Communicating effectively

All but two patients who completed a HIW questionnaire told us that they were always able to speak to staff in their preferred language. The majority of patients who completed a questionnaire felt that things were always explained to them during their appointment in a way that they could understand. In addition, they felt that they were involved as much as they wanted to be, in decisions made about their care.

The practice staff that we spoke to confirmed that a hearing loop was not available for the benefit of patients or visitors. A hearing loop is used to help people who have hearing difficulties, to hear better and communicate effectively.

The staff confirmed that they could access a translation service to help communication with patients who did not speak English, to understand what was being said during their consultations with the GP or nurse and vice versa. We were also told that patients were encouraged to bring someone with them if there were occasions where language barriers were expected, or if it was difficult to access the translation service.

There were no signs available to direct and orientate patients to the consultation rooms and other facilities. However, there was signage on the consultation room doors. The visual call system was not working during our inspection however, there was and audio call system in place and patients were called by number.

We considered the arrangements in place for when patients required contact from the practice for additional requirements. For example, to return for a follow up appointment, a blood test, or to receive treatment/ prescription, based on test results. We were told that the practice staff would either telephone the patient/carer or write to them informing them for example, to book an appointment or collect a prescription.

Internal messages are communicated verbally and electronically. Electronic format allows for an audit trail of messages sent and received. Daily messages are addressed by the GP working within the practice that day, to avoid leaving messages for specific GPs to follow up.

We spoke to staff regarding electronic discharge summaries received from local hospitals. The administrative staff said that once received at the practice, these would be forwarded by the team leader to the GP on duty that day for any action required.

Improvement needed

The practice is required to provide HIW with details of the action it will take to ensure that:

- A working hearing loop is readily available at the practice for the benefit of patients and visitors
- Signs are installed to direct and orientate patients to the consultation rooms and other facilities.

Timely care

The practice opens its doors to patients between 8:30am to 6:00pm Monday to Friday, although the phone lines remain open from 8:00am until 6:30pm. The practice does not offer appointments every other Wednesday afternoon, as this time is protected for training, however, an on-call GP service is available for emergencies. Whilst on the day appointments were offered, patients are required to telephone the surgery from 8:00am onwards to secure an appointment that same day.

There was a system in place where a GP always telephones the patient in the first instance, to establish if it was necessary for them to attend the practice in person, or whether they could consult over the telephone, or refer to other services. There were occasional follow up appointments made for some patients, such as those who require making additional arrangements in advance with carers, to accompany them to the practice. However, the same process existed on the appointment day where the GP would first telephone the patient, prior to them arriving at the practice, to establish if they still required face to face consultation.

Any patients with additional needs such as; physical disabilities, sensory loss, learning disabilities or those that are housebound are highlighted within the electronic system called Vision, to ensure that the practice staff are immediately alerted to this, via a Read Code[3].

The majority of patients who completed a questionnaire told us that they were very satisfied or fairly satisfied with the hours that the practice was open. However, just over a third of patients told us that it was not very easy or not at all easy to get an appointment when they need it. When asked to describe their overall experience of making an appointment, the majority of patients who completed a questionnaire, described their experience as good or very good.

The practice nurse runs a number of chronic disease management clinics, where patients are monitored and given advice on managing their conditions. This service aims to reduce demand for appointments with GPs whilst ensuring

[3] Read codes are a set of clinical computer generated codes designed for use in Primary Care to record the everyday care of a patient. The codes also facilitate audit activity and reporting within primary care.

that patients are seen by an appropriate healthcare professional. This allows more time for GPs to see those patients with more complex health conditions.

We were told that the HCSW also runs some chronic disease management clinics and may also provide immunisations to babies. We have concerns regarding this practice, and this is discussed in further detail under the Delivery of Safe and Effective Care section of this report.

The practice offered home visits to patients who were too ill to attend the practice and those who were housebound.

Arrangements were in place, via the health board, to provide cover for urgent medical care out of hours. Most patients who completed a questionnaire told us that they would know how to access the out of hours GP service.

Senior staff confirmed that whilst in-house second opinions were used, the process for this was generally informal. These aim to ensure that patients receive the most appropriate ongoing care.

We were informed that non-urgent referrals were made within three to five days after this had been agreed with the patient. Urgent referrals were completed sooner, for example; the practice used urgent suspected cancer protocols to ensure that patients received care and treatment in a timely way. Practice staff confirmed that a system was in place to check that referrals had been received and acted upon by secondary care (hospital) services.

We were informed that the practice had a phlebotomy service which was undertaken by the practice health care assistant and practice nurse. If they were unavailable, the practice nurse, or doctors could obtain patients' blood samples if urgent, to ensure timely care.

Individual care

Planning care to promote independence

Patient facilities at the practice were located on the ground floor. Entry to the practice was suitable for wheelchair users and for those with other mobility issues. However, a very small number of patients who completed a HIW questionnaire felt that it was not very easy to get into the practice. One patient commented on how the practice could improve the service it provides:

> *"By providing automatic doors for people in wheelchairs from reception to doctor's room. Very difficult to open. Never*

anyone around to help hold the doors open. The receptionist will not get up to offer help".

The main reception desk had a low-level section which would enable a wheelchair user to easily speak with reception staff if required. The doorways inside the building were mostly wide enough to allow safe use of wheelchairs, motorised scooters and pushchairs.

There were no car parking spaces available for patients. To the front of the practice, there were double yellow lines so patients and visitors could not park there. In addition, there was also very little parking available in the nearby residential area.

We were told that patients could park in the nearby train station car park and there was also a multi-storey car park approximately 5-10 minutes' walk away, however, these options are not suitable for some patients with mobility issues or who are unwell.

There were male and female toilets situated within the ground floor near the waiting area. They were also suitable for disabled patients. This promoted the independence of patients with mobility issues.

People's rights

We found that peoples' rights were promoted within the practice with arrangements in place to protect peoples' rights to privacy. In addition, we saw staff treating patients with dignity, respect and kindness.

We also found that patients could be accompanied by their relatives or carers within the practice and during consultation or treatment if desired. Practice staff also confirmed that patients could have a chaperone present during their consultations.

We were told that staff had completed General Data Protection Regulation (GDPR) training, however, there were no certificates or evidence available to support this. Issues around training evidence will be discussed in further detail under the Quality of Management and Leadership section of this report

Listening and learning from feedback

Within the reception and waiting area, there was a suggestion box available where patients could provide verbal comments and suggestions. However, the practice did not have any pens or paper readily available for patients to document their comments. However, we were told by staff that patients could

ask for pen and paper at reception for this purpose. It may be of benefit to advertise to patients that they could ask at reception for these provisions.

There was no system in place for recording verbal concerns/complaints, but formal or written complaints were recorded. In addition, response times, to concerns raised by patients, were not compliant with the NHS Wales Putting Things Right process. There was minimal information available for patients on the Putting Things Right process, as highlighted earlier.

Improvement needed

The practice is required to provide HIW with details of the action it will take to ensure that it will develop a system for the recording and response to verbal concerns or complaints received from patients or relatives/carers, in-keeping with the Putting Things Right process.

Delivery of safe and effective care

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

We found that the practice was not always equipped to provide safe and effective care to patients. This was because there was minimal resuscitation equipment available and we did not see evidence that all staff were appropriately trained to undertake or provide specific aspects of care.

We identified that the GPs had a good knowledge of current guidelines produced by the National Institute for Health and Care Excellence (NICE) and any issued National Patient Safety Alerts. However, improvement is required to ensure that this information is disseminated and discussed promptly with other relevant members of the team.

A good policy in relation to infection prevention and control was in place and it accurately reflected the current arrangements in relation to infection control audit activity and cleaning schedules. There was also a policy in place for blood borne viruses.

Safe care

Our concerns regarding the availability of resuscitation equipment and resuscitation update training 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 and can be seen under the subheading; Medicines Management.

Managing risk and promoting health and safety

The premises were owned by the local health board and the practice had been providing services within them for five years. The entire premises were found to be visibly clean and well-organised,

Senior staff stated that there were arrangements in place with the other two group practices, should the practice not be able to operate out of the existing building. The information technology (computer) system could be accessed through all three sites. In addition, the telephone lines could be answered within all three practices and also from home.

The practice had a business continuity plan in place for guidance on dealing with other service delivery issues.

There were appropriate fire and safety risk assessments in place and all electrical equipment was suitably portable appliance tested (PAT)[4].

Infection prevention and control

There were no concerns raised by patients over the cleanliness of the practice, and most patients that completed a HIW questionnaire felt that in their opinion, the premises was very clean.

Hand washing and drying facilities were available in key areas of the practice, however, there were no paper towels in male of female toilets and no working hand dryer in one of the toilets. In addition, there were hand sanitising dispensers readily available within all clinical areas, however, hand sanitising dispensers were not readily available in the public areas either. We were told that patients and visitors could ask for hand sanitising gel if they required it.

The waiting areas, corridors, treatment rooms and consulting rooms all appeared visibly clean. We saw that personal protective equipment (PPE) such as gloves and disposable aprons were available for use by clinical staff to reduce the risk of cross infection.

Each of the treatment and consulting rooms had washable flooring, worktops and cabinets to facilitate effective and easy cleaning.

We saw that domestic (household) waste and clinical waste (including medical sharps for example, needles) had been segregated into different and

[4] Portable appliance testing (PAT) is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use. Most electrical safety defects can be found by visual examination but some types of defect can only be found by testing.

appropriate coloured bags/containers to ensure it was disposed of safely and correctly. Clinical waste awaiting collection was securely stored to prevent unauthorised access.

Policies for infection prevention and control and blood borne viruses were in place and they accurately reflected the current arrangements in pace, in relation to infection control audit activity and cleaning schedules. We found that an infection control audit had recently taken place.

We were told that all clinical staff had undertaken infection prevention and control training however, we did not see evidence of this. This is addressed later in the report.

We saw evidence that individual records had been kept for all clinical staff in relation to their Hepatitis B immunisation status.

All consulting and treatment rooms were fitted with fabric dignity curtains around the examination couches. The practice could consider using disposable curtains to help prevention or reduce the risk of cross infection.

Improvement needed

The practice is required to provide HIW with details of the action it will take to ensure that:

- Hand drying facilities are always available within the patient toilets
- Hand sanitising gel or foam is readily available with public waiting areas.

Medicines management

The practice used the local health board formulary (and crosschecked where required with the British National Formulary[5]), to refer to specific medications

[5] The British National Formulary is a United Kingdom pharmaceutical reference book that contains a wide spectrum of information and advice on prescribing and pharmacology, along with specific facts and details about many medicines available on the UK National Health Service. Information within the BNF includes indication(s), contraindications, side effects,

where required. Arrangements were in place to ensure that the most up to date information was used in accordance with local and national guidance. This meant that GPs prescribed medication from a preferred list of approved medicines.

Senior staff confirmed that reviews of patients' repeat medication were undertaken. This was done during some consultations, through hospital clinics, and when the GPs and pharmacists undertake medication reviews of the patients. Where it was identified that patients were no longer taking medicines, we were told these medicines were removed from the repeat prescribing list.

We were told that some admin team members, who were responsible for preparing repeat prescriptions, were altering them without initially discussing this with a GP, if the patient's prescription had been changed prior to being discharged from hospital. These repeat prescriptions were then passed to the GP for their signature, before issuing to the pharmacy or patient.

We had concerns with this process and addressed this with the practice manager and GP present during the inspection. This is because the admin staff are not clinically trained to recognise the potential consequences of making changes to usual prescriptions, such as dose changes, discontinuing or commencing new medication. This is particularly important where a patient may not have disclosed all medication to the medical teams, whilst an inpatient (or outpatient) in hospital. We were told that the relevant admin team members were experienced at this, both the GP and practice manager were confident that this process was robust, and that there had never been any issues to date.

We asked for evidence of their training, education and competency assessment for this, and also asked what audit process was in place, to ensure that this was always done appropriately and correctly. We were not assured that any training had taken place, competency was appropriately assessed, or that an audit was undertaken regularly.

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doses, legal classification, names and prices of available proprietary and generic formulations, and any other notable points.

Within the sample of patients' medical records we reviewed, we saw the reasons for prescribing medication had been recorded. Recording this information helps inform decision making when reviewing treatment at future consultations. We also saw a consistent approach to the documentation. In addition, the records we reviewed included the reasons why a patient may have stopped their medication. Similarly, recording such reasons also helps to inform future consultations.

During the inspection we were told that the practice HCSW has a number of extended roles. This includes administering vaccinations, including vaccinations to babies. In addition to this, the HCSW also undertakes chronic disease management clinics such as diabetic and chronic respiratory disease clinics. We had concerns that an unregistered member of the clinical team was undertaking such roles so we raised this with the GP and Practice Manager who were present during the inspection day.

In relation to administering vaccines, the Royal College of Nursing (RCN) and Public Health Wales (PHW), supports the role of the HCSW in administering specific vaccines. The National Minimum Standards and Core Curriculum for Immunisation Training of Healthcare Support Workers (2015)[6] document, sets out the minimum framework for developing training to meet the needs of HCSWs administering influenza, shingles and pneumococcal vaccinations to adults and the live attenuated intranasal influenza vaccine to children.

The standards also include ensuring that HCSWs are appropriately trained and have the support of a registered health care professional (GP or nurse in primary care). The RCN and PHW do not support HCSWs administering other vaccines such as the remainder of the childhood vaccination program or travel vaccines. This also includes the administration of immunizations to babies. This is due to the clinical decision-making involved.

We were told by the practice manager that the HCSW was competent to undertake vaccine administration and chronic disease management clinics. This was because she had undertaken courses at university to enable her to carry out these roles, and that she was deemed competent to do so. We asked

[6] National Minimum Standards and Core Curriculum for Immunisation Training of Healthcare Support Workers (2015)

to see evidence of the university training and competency sign off, but this was unavailable on the day of inspection. The practice manager said that she would send this information on to HIW following inspection, however, we have not received it.

We expressed our concern that the HCSW should not be providing any immunisations to babies, since this is not supported by the RCN or PHW, and we recommended that the HCSW does not continue to vaccinate babies and young infants, to which they agreed.

The resuscitation Council UK quality standards for resuscitation[7] stipulate, that healthcare organisations have an obligation to provide a high-quality resuscitation service, and to ensure that staff are trained and updated regularly to a level of proficiency appropriate to each individual's expected role. The inspection team considered the arrangements for the checking of resuscitation training evidence and resuscitation equipment and drugs. This is because a patient could collapse at the practice at any time, whether they have received treatment or not. It is therefore essential that all registrants are trained in dealing with medical emergencies, including resuscitation, and possess up to date evidence of capability.

During the inspection, we identified that there were minimal items available to assist with resuscitation in the event of an emergency such as; a patient collapse, anaphylaxis (severe allergic reaction), or cardiac arrest. In addition, we could not find evidence to demonstrate that any clinical staff had received resuscitation update training within the last 12 months, or that all clinical and non-clinical staff had received any resuscitation training in the past.

The practice had oxygen available, along with adult and paediatric face masks with reservoir bags. However, the oxygen cylinder we saw was near empty, with the gauge at the higher end of the red zone.

There were a number of key items absent for resuscitation, and this included the following:

- Pocket mask with oxygen port for adults and children

[7] Resuscitation Council UK Quality Standards for Resuscitation

- Oxygen cylinder with adequate amount of oxygen
- Automated External Defibrillator (AED), with facilities for paediatric use as well as use in adults
- Adhesive defibrillator pads for adults and children, with spare sets
- Portable suction with Yankauer sucker[8] and soft suction catheters
- Oropharyngeal airways and clear face masks in sizes 0, 1, 2, 3, 4
- Algorithms, emergency drug doses, paediatric drug calculators.

All staff in a primary care organisations, including non-clinical staff, should undergo regular training in resuscitation of both adults and children to the level appropriate to their role. Staff should undergo such training at induction and at appropriately frequent, regular intervals thereafter, to maintain knowledge and skills. Clinical staff should have at least annual updates, and the training and updates that include an assessment, are recommended for clinical staff. Non-clinical staff should generally have annual updates also. However, a local risk assessment may be undertaken to assess the likelihood of non-clinical staff encountering a patient requiring resuscitation.

The required equipment, drugs and checks are highlighted by guidance produced by the Resuscitation Council (UK).

Our findings above were dealt with under our immediate assurance process. The process was discussed with the practice manager and GP present on the day of inspection, and we informed them that HIW required immediate action from them. On the day of inspection, they contacted the Resuscitation Council UK for advice, and also immediately commenced the process to obtain and purchase all the required equipment for emergency situations. We saw evidence of this on the day of inspection.

[8] The Yankauer suction tip is an oral suctioning tool used in medical procedures. It is typically a firm plastic suction tip with a large opening surrounded by a bulbous head and is designed to allow effective suction without damaging surrounding tissue. This tool is used to suction oropharyngeal secretions in order to prevent aspiration (inhaling oral or gastric secretions to the lungs).

We also wrote to the practice immediately the day after inspection, with details of the immediate action we required. The health board was also contacted the day after inspection, regarding the issues we found in relation to resuscitation equipment and training requirements. We have since received sufficient assurance that the practice is now adequately equipped for emergency situations. However, resuscitation training was due to be undertaken by all staff on 20 February 2019. The practice manager told us that she would send evidence of training completed for all staff following this.

Improvement needed

The practice is required to provide HIW with details of the action it will take to ensure that:

- The process for preparing prescriptions and amending patient prescriptions following hospital discharge advice, is carefully reviewed, and that the knowledge, skills and competence of the admin staff who prepare the prescription is reassessed robustly
- An audit process is commenced to ensure that the prescription process is undertaken correctly by members of the admin team
- HIW are provided with evidence to demonstrate that the HCSW has completed university training and evidence of competency sign off, to enable her to provide vaccinations and to undertake chronic disease management clinics.
- HIW are provided with evidence of the HCSW's job description which should specify their role in undertaking advanced roles
- HIW are provided with evidence that the practice has appropriate medical indemnity for the HCSW they employ, and that the cover provided is sufficient to cover their scope of practice.

Safeguarding children and adults at risk

A policy and other forms of written procedures in relation to safeguarding children and adults at risk were available within the practice. Such procedures aim to promote and protect the welfare and safety of children and adults who are vulnerable or at risk.

Arrangements were described for recording and updating relevant child protection information on the electronic patient record system. Senior staff confirmed that a designated GP at the practice was a lead for child and adult protection/ safeguarding. This meant that staff had a local contact person to

report, and discuss, concerns in relation to safeguarding issues. However, on discussion with other staff members, they were not aware of who the lead was, if they needed to escalate any concerns to them. The practice should ensure that all staff are aware of who the lead for safeguarding is.

We were told by senior staff that the GP lead for safeguarding undertakes regular reviews of the child protection register along with a health visitor. Health visitors were attached to the practice and arrangements for multi-professional working were described to promote the welfare and safety of children. We were told that with any identified child protection issues or amendments required, alerts were placed or removed within the electronic patient system where applicable.

Other staff we spoke to confirmed that, should they have any concerns around the welfare of a patient, they would report this to senior practice staff.

We did not see evidence that staff had undertaken any safeguarding training for children or adults at risk.

Improvement needed

The practice is required to provide HIW with details of the action it will take to ensure that, all staff undertake safeguarding training to the required levels relevant to their role, and they must provide evidence to HIW that the training has been completed.

Medical devices, equipment and diagnostic systems

With the exception of the absent defibrillator as discussed above, all medical devices, equipment and any diagnostic systems were in a good state of repair. They were well maintained and fit for purpose and where appropriate, had been electronically safe tested.

Effective care

Safe and clinically effective care

The National Reporting and Learning System (NRLS) is a central database of patient safety incident reports. Since the NRLS was set up in 2003, the culture of reporting incidents to improve safety in healthcare has developed substantially. The database allows healthcare professionals to record, share and use vital information following patient safety incidents, so they can share

learning and provide better, safer and more efficient care. We did not see evidence that there was a system in place for accessing or sending information to NRLS. We advise that the practice considers using the NRLS, for the benefit of patient care and staff knowledge.

We identified that significant patient safety incidents were discussed during specific set meetings. However, we were told that minutes were not routinely taken due to the sensitive information disclosed. The absence of minutes may prevent shared learning through the wider team. Anonymising the patient details would help maintain confidentiality.

We identified that the GPs had a good knowledge of current guidelines produced by the National Institute for Health and Care Excellence (NICE)[9] and any national patient safety alerts. However, there was no evidence of formal discussion of those guidelines with other relevant members of the team.

Senior staff confirmed that relevant safety alerts were circulated on an ad hoc basis throughout the practice team as necessary, and usually at team meetings. Arrangements were also described for discussing and keeping staff up to date with best practice and professional guidance.

We were told that any relevant information, as discussed above, was disseminated to all staff via email and an electronic notice board. However, the practice did not keep a log of who had read and understood the information shared. We advise that the practice records where staff have read the relevant shared information along with any relevant meeting minutes. This is to maintain effective communication and shared learning to promote patient safety.

Improvement needed

The practice is required to provide HIW with details of the action it will take to ensure that significant events and new guidelines are always shared with staff in a formal and timely manner.

[9] The role of the National Institute for Health and Care Excellence is to provide patients, health professionals and the public with authoritative, robust and reliable guidance on current 'best practice'.

Information governance and communications technology

Information governance was good in relation to the security of electronic patient data and their medical records. However, we did not see evidence that staff had completed training in information governance.

Improvement needed

The practice is required to provide HIW with details of the action it will take to ensure that all staff complete information governance training.

Record keeping

As previously described, we reviewed a sample of patient medical records. These were in an easy to navigate electronic format, and were secure against unauthorised access.

Entries made in the medical records were mostly satisfactory. In the main, notes were suitably detailed to help inform decision making at subsequent consultations and so plan patients' ongoing care and treatment. However, we did find that more clinical findings could have been documented on a particular occasion within one patient record. In addition, a patient who had a positive blood test to diagnose gout, and had recurrent episodes of gout, had not been prescribed any medication for this. There was no explanation in the notes as to why not, or if this was recommended to the patient at the time of consultation.

We saw that most records included key information such as the identity of the clinician recording the notes, the date and the outcome of the consultation. The records showed that entries had been made in a timely manner following each consultation, including home visits. We saw that Read codes were used effectively within the sample of medical records we reviewed.

Arrangements were described for summarising information in patients' electronic medical records. We were told that only clinical staff summarised records. Summarising information helps ensure that GPs and nurses have easy access to a patient's relevant past medical history to help inform care and treatment decisions effectively and efficiently.

There was no process in place for regular peer review/audit of the quality of data entry within patient records. Therefore, we advise that the practice considers undertaking regular peer review or audits of data entry.

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.

Overall, we found that the practice was generally well run. The staff team were happy in their work and said that they felt well supported by the senior team and GP partners.

We identified that some written policies and procedures required review to ensure they reflect current arrangements at the practice.

Arrangements are required to ensure that all staff training that is relevant to their role, is completed and is up to date, and that evidence is readily available at the practice for this.

Governance, leadership and accountability

At the time of our inspection, the practice was owned and operated by four GP partners. A full-time practice manager was also in post and was responsible for the day to day management of the practice. She also managed the Rosedale Medical Groups' other two practices. There was a deputy practice manager also based at the Alfred Street practice, as well as within the other two practices.

Staff told us that they were happy in their work and said that they felt well supported by the senior team and GP partners. In addition, we found that the practice manager was forward thinking and was looking at opportunities to generate improvements and income for the practice.

There was no designated lead clinician for governance, quality assurance and quality improvement. We were told that all partners took responsibility for this. We were told that there was also a clinical governance folder available. However, we did not see evidence of a programme of audits, their results or any actions from these.

We found that the team of administrative staff had a number of roles and responsibilities. This meant that staff could provide cover for each other during

absences, reducing the risk of disruption to services for patients. This included covering throughout all three practices within the group.

We were told that there was a willingness within the practice team to support and develop staff through shared and experiential learning, to improve the services provided to patients. However, we did not see evidence of regular or updated study days or courses such as; safeguarding children and adults at risk, CPR, fire safety training, GDPR, infection, prevention and control and immunisation training for HCSW and chronic disease management training for HCSW.

The practice did not hold an easily accessible training matrix or evidence of training certificates to record and monitor any training undertaken by the medical, nursing or administrative staff. The use of a completed training matrix and holding copies of training certificates would ensure that any update training could be booked and attended promptly before expiry.

Clinical cases were reported as being discussed but on an informal basis between GPs. However, nursing staff were not usually present or invited to those meetings. The inspection team therefore advised that all relevant clinical staff should be involved in regular clinical meetings, for the purposes of learning and continuity of patient care.

There were regular practice meetings between the GPs and practice manager. However, there were no minutes available for us to see, and therefore no evidence that formal records were made to ensure that actions were followed through and who was responsible for them.

Other staff meetings were usually held once a month, however, these were informal and with the absence of meeting minutes. Whilst there was some evidence of information giving (which was relevant to practice functions), there was little evidence of the promotion of two way discussions and opportunities for staff to offer suggestions and ideas.

The practice was part of a local GP cluster. We were told that the GPs and practice manager attended local cluster meetings regularly. This helps promote cluster working and engagement as well as some shared learning. However, there was no evidence of how relevant information from these cluster meetings is disseminated to other doctors in the practice and practice staff. We were told that the practice manager shared this information following cluster meetings. However, when we spoke to some staff, they were not aware of this information.

The practice had in place a practice development plan. This identified a number of actions to maintain and develop the services provided and included timescales for completion.

A range of written policies and procedures was available to guide staff in their day to day jobs. Staff we spoke to were aware of how to access these. Whilst policies and procedures were in place, we identified that some did not reflect the current arrangements as described by staff, and they required updating. In addition, there was a need for version control arrangements to be put in place and for a register to be maintained to demonstrate that staff had read and understood the policies.

Improvement needed

The practice is required to provide HIW with details of the action it will take to ensure that:

- Relevant audits are undertaken and results, actions and outcomes are shared through the team
- A record of all mandatory training attendance and other relevant training, is recorded for all staff working within the practice. This should include; safeguarding children and adults at risk, CPR, fire safety training, GDPR, infection, prevention and control and immunisation training for HCSW and chronic disease management training for HCSW
- Relevant information from cluster meetings is shared with GP partners and practice staff
- A review and update is undertaken of the practice policies and procedures to ensure that they accurately reflect the current arrangements at the practice and that they are up to date along with version control.

Staff and resources

Workforce

The practice staff that we spoke to were able to describe their particular roles and responsibilities, which contributed to the overall operation of the practice. Staff working within the practice also worked flexibly. This meant that staff could provide cover for each other during absences as highlighted earlier, to reduce

the risk of disruption of services to patients, by working between each of the three practices at short notice.

Comments from staff indicated that they were supported to attend internal and some eLearning/training relevant to their role. However, as previously referenced, we did not see evidence that all staff were up to date with mandatory training as highlighted above.

Arrangements were described for staff annual appraisals and we saw an example of a completed appraisal within a staff file. However, this was not dated, and neither was it signed or dated by the manager or employee. We therefore we could not be assured that all staff had received an appraisal within the last twelve months. An annual appraisal process will help identify the performance, training and development needs of staff. This can also provide an opportunity for managers to give feedback to staff about their work.

In the files we checked, there was evidence to show that recruitment checks, such as written references and also a Disclosure and Barring Service (DBS) check to the required level, had been conducted to ascertain whether staff were suitable to work at the practice. However, we did not see evidence that there was a robust induction plan in place that would cover all aspects of induction along with mandatory training requirements.

Improvement needed

The practice is required to provide HIW with details of the action it will take to ensure that a robust induction list is in place and completed to ensure a standardised approach with all members of staff new to the practice.

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, measurable, 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: Alfred Street Primary Care Centre

Date of inspection: 21 January 2019

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
The practice is required to provide HIW with details of the immediate action it will take, to ensure that: • Emergency resuscitation equipment and medication is always available, fully functional and safe to use, in the event of an adult and paediatric patient emergency • All clinical staff have appropriate resuscitation training with annual updates • All non-clinical staff receive resuscitation training with regular	Standard 2.6 & 2.9	1- Emergency resuscitation equipment has been delivered including Defib – with pads for adults, oropharyngeal and clear masks, IV Lines, Fluids lines child's defib pads and spare pads ETA 28/01. Replacement oxygen is due for delivery 25/01, suction machine and ALL other equipment including trolley for storage due for delivery	Dr H M Perry	Immediately

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
updates. Due to the concerns around the lack of resuscitation equipment and adequate training of staff, HIW would strongly advise that the practice consider ceasing the administration of vaccinations and the carrying out of any minor surgery. This should be until they are assured they have the appropriate equipment and that staff are adequately trained.		24/01/2019. – Algorithms and meds charts available 22/01/2019 ready to be attached currently displayed on wall. 2- SOP and Spreadsheet developed outlining expectations with checking of trolley and meds to be dated and signed bi weekly (find sop attached) 3- New SOP's surrounding CPR BLS attached. 4- All Staff in Practice clinical and non-clinical, have been booked on a private resuscitation training by Lupus on 20/02/2019. This is a full day split into sessions. Accompanied with spread sheet to include all staff for		

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		above training created to ensure update is arranged annually (attached). 5- Meeting arranged with all nursing team and NON CLINICAL STAFF Dr Perry to discuss familiarising with all equipment 25/01. 6- All staff 23/01/2019 where briefed by partners with regards to their roles and responsibilities.		

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: Alfred Street Primary Care Centre

Name (print): Roisin Jones

Job role: Practice Manager

Date: 24 January 2019

Appendix C – Improvement plan

Service: Alfred Street Primary Care Centre

Date of inspection: 21 January 2019

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 is required to provide HIW with details of the action it will take to ensure that: The dignity curtain around the examination couch is replaced, and others if appropriate All patients are aware of the availability of a chaperone if required, prior to receiving consultation Information for the provision of a chaperone is clearly displayed for all	4.1 Dignified Care	New portable dignity screen purchased and at practice. Telephone message to be altered to inform patients of the availability of chaperones. Patient information poster in practice displayed multiple times in waiting room, and in clinical rooms.	Roisin Jones Roisin Jones Rhian Rooke. Team Leader	Purchased 12/02/19 To be completed by 15/03/19. Ongoing.

Improvement needed	Standard	Service action	Responsible officer	Timescale
patients within the waiting area and consulting/ treatment rooms.				
The practice is required to provide HIW with details of the action it will take to ensure that: Formal communication is undertaken with the local health board regarding the current website, to ensure that the details they provide for the practice are removed, to prevent misinformation to patients The practice's patient information leaflet is reviewed to ensure that it contains relevant and useful information about the practice including the services offered, PTR complaints process and up to date general data protection regulation information All patients are aware of the Putting Things Right process by displaying information appropriately within the practice	4.2 Patient Information	We have proactively been tracking down the appropriate people to amend the NHS wales website – we have formally communicated via email with the primary care team at ABMU to help last communication regarding this was made 08/03. The practice leaflet has totally been re-written from scratch this includes information of the services provided, PTR complaints process and where to get further information and a brief outline of the GDPR information. The PTRP handout has been moved from behind the practice reception and into the main area where there are multiple copies available, an email has also been circulated to make	Roisin Jones Roisin Jones Rhian Rooke (Team leader)	18/03/19 Completed – website is referred to is now amended. Ongoing, this will constantly need to be updated. Ongoing.

Improvement needed	Standard	Service action	Responsible officer	Timescale
That Putting Things Right information leaflets are readily available for patients to read and take away The current consent policy is reviewed and updated.		receptionists aware that they must check weekly the amount available to patients in the waiting areas. Our current consent policy is with our DPO in NWIS for review and appropriate updates.	Roisin and DPO	01/04/19 and annual rev.
The practice is required to provide HIW with details of the action it will take to ensure that: A working hearing loop is readily available at the practice for the benefit of patients and visitors Signs are installed to direct and orientate patients to the consultation rooms and other facilities.	3.2 Communicating effectively	Practice has been working with the Estates manager Jonathan Parker from the Local Health Board regarding the implementation of both signs and hearing loops we have had multiple contractors out for quotation – a contractor has been employed.	Roisin Jones and Jonathan Parker LHB.	01/05/19
The practice is required to provide HIW with details of the action it will take to ensure that, it will develop a system for the recording and response to verbal concerns or complaints received from patients or relatives/carers, in-keeping with the Putting Things Right process.	6.3 Listening and Learning from feedback	We have a working live document employed for the logging of the concerns and all staff have access to update this. A notification via email and push notification is received by partners, team leaders and PM when a new concern or complaint is received.	Roisin Jones – Partner Dr P Williams	Ongoing.

Improvement needed	Standard	Service action	Responsible officer	Timescale
		The excel document also allows for tracking of complaint for up to date feedback to be passed to the patient as and when requested.		
Delivery of safe and effective care				
The practice is required to provide HIW with details of the action it will take to ensure that: • Hand drying facilities are always available within the patient • Hand sanitising gel or foam is readily available with public waiting areas.	2.4 Infection Prevention and Control (IPC) and Decontamination	Cleaning contractor who also handles all consumables and the implementation of the patient hand drying facilities. The admin staff have also been given a supply of hand towels and expectations of regular facilities checks have been circulated via email. In addition new signage for patients to advise patients if there are no facilities available to make staff aware. New wall mounted hand sanitisers and holders have been ordered from Williams Medical. Our handy man is aware of their impending arrival – we have been given a delivery date of 13/03/19	Roisin Jones Roisin Jones	4 days from 11/03/19 Delivered and installed.

Improvement needed	Standard	Service action	Responsible officer	Timescale
The practice is required to provide HIW with details of the action it will take to ensure that: The process for preparing prescriptions and amending patient prescriptions following hospital discharge advice, is carefully reviewed, and that the knowledge, skills and competence of the admin staff who prepare the prescription is reassessed robustly An audit process is commenced to ensure that the prescription process is undertaken correctly by members of the admin team HIW are provided with evidence to demonstrate that the HCSW has completed university training and evidence of competency sign off, to enable her to provide vaccinations and to undertake chronic disease management clinics HIW are provided with evidence of the	2.6 Medicines Management	The practice has arranged an update with medicines management via the cluster pharmacy technician with prescribing clerk training – date to be agreed due to ongoing issues with PT4L. We have reviewed the process of presentation and review of GP's for the discharges – designated staff with relevant training, will make the amendments as directed print a copy of the new prescription, attach to the discharge summary, and present these separately to all other prescriptions at a different time. Each individual prescription is audited by the GP on site before prescription is handed to patient. Please find attached as requested, and a letter from Partner Dr H Perry. As addressed when the LHB visited, it was discussed that we would look to qualify our HCA as discussed at cluster level	Dr Kristy Mellin and Rebecca Clatworthy (senior practice employed pharmacist). Dr Kristy Mellin and Rebecca Clatworthy (senior practice employed pharmacist). Dr H Perry.	Arranged for 02/04/19 Ongoing. Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
HCSW's job description which should specify their role in undertaking advanced roles HIW are provided with evidence that the practice has appropriate medical indemnity for the HCSW they employ, and that the cover provided is sufficient to cover their scope of practice.		to do child vaccinations no evidence could be found that our HCA administered any immunisations outside of the remit of any experienced HCA including but not limited to baby imms in clinic at any time. Our HCA is currently covered vicariously by our GP Partners cover. As confirmed by the email included, with the Welsh risk pool taking on indemnity we have applied to MPS for allied health professional cover that will commence on 01/04/2019 – we are yet to receive our certificate. We will continue on with our HCA working non independently completing diabetic reviews, asthmatic and COPD revs and passing more complex issues onto our Practice Nurse and GP Partners for further management.		
The practice is required to provide HIW with details of the action it will take to ensure that all	2.7 Safeguarding children and	All staff have now been signed up to the HOWIS and NHS supported	Roisin Jones	Ongoing – Safeguarding

Improvement needed	Standard	Service action	Responsible officer	Timescale
staff are trained to the required levels 1, 2 or 3 relevant to their role. They must also provide evidence to HIW if the training has already been undertaken for all staff.	adults at risk	learning portal https://learning.wales.nhs.uk/ - we have now from 01/03/19 allocated each staff member with 1 hour personal development time to complete the necessary obligatory training and then complete further training of their choice.		to be completed to Level 1 & 2 by all staff by 28/06/19
The practice is required to provide HIW with details of the action it will take to ensure that significant events and new guidelines are always shared with staff in a formal and timely manner.	3.1 Safe and Clinically Effective care	All new significant events are logged in the same way as complaints – we are moving forwarded having minutes circulated bi-weekly clinical meetings where the SEA's with be discussed at length.	Dr P Williams	Ongoing.
The practice is required to provide HIW with details of the action it will take to ensure that all staff complete information governance training.	3.4 Information Governance and Communications Technology	We have formally requested practice based IG training from our DPO in NWIS or guidance as to what agency we can approach to provide this training – alternatively we will look to continue with the theme of online training and sign our staff up to https://www.skillsplatform.org/courses/2314-information-governance.	Roisin Jones	We aim for practice based training by NWIS or external agency for all staff by 01/05/19

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of management and leadership				
The practice is required to provide HIW with details of the action it will take to ensure that: Relevant audits are undertaken and results, actions and outcomes are shared through the team A record of all mandatory training attendance and other relevant training, is recorded for all staff working within the practice. This should include; safeguarding children and adults at risk, CPR, fire safety training, GDPR, infection, prevention and control and immunisation training for HCSW and chronic disease management training for HCSW Relevant information from cluster meetings is shared with GP partners and practice staff and demonstrate how cluster developments are included in the practice development	Governance, Leadership and Accountability	Audits that are carried out are to be discussed in the bi weekly clinical meetings and added to the agenda which is circulated as a standing item. New records of mandatory training have been developed by our HR Team Croner. Copies of all training certificates are scanned and added to each person's personal profile on the web based system. Our HCA will continue to attend PT4L when limited services are run by practice to ensure that mandatory training including infection control and PGD directed immunisations such as flu vaccinations updates (not childhood imms) are met. This will then be recorded on the online portal supplied and protected by Croner.	Roisin Jones Roisin Jones Roisin Jones,	Ongoing Created and all of the information loaded 06/02 Ongoing in order to keep files up to date etc. Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
plan A review and update is undertaken of the practice policies and procedures to ensure that they accurately reflect the current arrangements at the practice and that they are up to date along with version control.		Updates of policies have been completed along with version controls and have been submitted to the health board, via CGPSTAT and IG Toolkit. Cluster information including the cluster development plan is kept in a communal and easily accessible area within the PM office. Agendas are shared on web based information sharing and job management app SLACK. This is also updated live from cluster. All staff have access to this relevant board within the Slack app.	Rhian Rooke Dr P Williams Roisin Jones	and ongoing. Ongoing
The practice is required to provide HIW with details of the action it will take to ensure that, a robust induction list is in place and completed to ensure a standardised approach with all members of staff new to the practice.	7.1 Workforce	We have enlisted the support from HR company Croner to generate a robust and appropriate to our business induction check list. This will be then re completed with each staff member currently employed and anyone who is employed going forward.	Roisin Jones	Induction checklist to complete by Croner 12/04/19. To completed with all current staff by 30/04/19. Ongoing with

Improvement needed	Standard	Service action	Responsible officer	Timescale
				new staff.

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): Roisin Jones

Job role: Practice Manager

Date: 11/03/2019, Re-submitted 25/03/2019