Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Abertillery Group Practice, Aneurin Bevan University Health Board

Inspection date: 12 June 2023

Publication date: 12 September 2023

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Digital ISBN 978-1-83504-660-9

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

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

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

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Abertillery Group Practice, Aneurin Bevan University Health Board on 12 June 2023.

Our team for the inspection comprised of two HIW Healthcare Inspectors, two clinical peer reviewers and a practice manager peer reviewer. The inspection was led by a HIW Healthcare Inspector.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 36 questionnaires were completed by patients or their carers and nine were completed by staff. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the setting and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
We found Abertillery Group Practice to be committed to providing a positive experience for their patients. We observed patients being greeted in a friendly, professional and courteous manner by staff who strived to meet their individual needs. We found there were processes in place to assure the privacy and dignity of the patient was always upheld. We also saw evidence that trained chaperones were available if required.

The overall environment was clean and tidy. There was level access to the practice allowing wheelchair users or those with mobility issues to access the facilities easily. The waiting room was spacious, and the treatment areas were all situated on the ground floor.

The practice had a good supply of health promotion material available, much of which was bilingual. Patients could also access this information digitally.

Arrangements were in place for patients who wished to communicate through the medium of Welsh, however we recommended that staff wear 'Iaith Gwaith' badges to advertise this further. We were advised that where a language other than English or Welsh was required, every effort would be made to facilitate this.

We found over half of the patients completing the HIW questionnaire were frustrated at access to appointments.

This is what we recommend the service can improve:

- Access to appointments
- Welsh speaking staff to be provided with 'Iaith Gwaith' badges.

This is what the service did well:

- Patients were treated in a caring and friendly manner within surgeries that preserved their dignity
- Access to written and digital health promotion materials
- Good facilities for patients with disabilities to access to the practice.

Delivery of Safe and Effective Care

Overall summary:
Overall, we found the team at Abertillery Group Practice were dedicated, hardworking and committed to providing patients with safe and effective care in an environment that was clean, tidy and free from visible hazards. All treatment rooms were of a good size and were well equipped.

Risk assessments were being undertaken regularly and there was evidence of appropriate policies and procedures.

Patient medical records that we reviewed were found to be clear and easy to navigate, however some improvements were required with appropriate read coding and completion of records by locums.

Whilst areas of good practice were seen, we did identify a small number of issues in relation to the storage of medication, expired medical items and equipment checks. These issues were dealt with under HIW's Immediate Assurance process.

Immediate assurances:

- Inappropriate storage of medication
- Expired items present within some clinical areas and the emergency equipment bag
- Comprehensive checklist required for the medications and equipment in the emergency bag.

This is what we recommend the service can improve:

- Managers to ensure all staff are aware of their roles and responsibilities
- Ensure a consistent approach to record keeping
- Ensure staff complete the level of safeguarding training relevant to their role.

This is what the service did well:

- Adherence to cold chain storage procedures
- Policies and procedures in place and current
- Good compliance with IPC guidelines and requirements.

Quality of Management and Leadership

Overall summary:
We found the practice had very good leadership and clear lines of accountability. The staff team worked very well together and were committed to providing a high standard of care for their patients. Staff had access to appropriate training opportunities to fulfil their professional obligations. They were encouraged and supported to undertake further relevant training to develop their careers.

There was evidence of a clear recruitment and induction process, followed by regular supervision and annual appraisals. Our review of staff mandatory training compliance found this to be good overall with some gaps present.

All staff meetings did not occur due to contracted changes with opening hours, however important information was being shared to all. We recommended the development of a formal process for team meetings that were minuted and disseminated accordingly.

This is what we recommend the service can improve:

- Formalise a process for team meetings to include all staff
- Implement a process to display outcomes of patient feedback that influenced improvements made at the practice.

This is what the service did well:

- Robust management structure in place at the practice
- Regular appraisals taking place for most staff
- Good access to training to allow for continued professional development.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Patient Feedback

Before our inspection we invited the practice to hand out HIW questionnaires to patients to obtain their views on the service provided at the practice. On the day of the inspection our inspectors also spoke with patients to find out about their experiences at the practice. Patient comments included the following:

> *"Thoroughly disillusioned with GP surgery problems. I feel as if I am a nuisance asking for an appointment. I dread to phone for an appointment this isn't right to have to feel this way. It needs to change and go back to how it used to be when you could book an appointment without all the hassle."*

> *"Waited seven days to see nurse for bloods and ECG after seeing doctor, could not breath no treatment given near on 3 weeks before results and next appointment with doctor, next time will go to A&E."*

We asked what could be done to improve the service. Comments included the following:

> *"Would like to ring any time of the practice hours and make an appointment"*

> *"I am elderly and I need time to get ready, can't just rush for an appointment this isn't considered when booking appointment"*

> *"Should be open Saturdays"*

> *"It would be easier to book appointments on a different day instead of ringing between 8am and 9am for same day appointments"*

Person centred

Health Promotion

During our inspection we saw that the practice had a good supply of health promotion information available to patients, displayed on dedicated noticeboards in the reception area.

We were shown a variety of health promotion information on the practice website and social media platforms. In addition, there were leaflets for patients to take away and we were advised that general practitioners (GPs) and nurses were able to print health promotion advice during a patient's consultation where required.

There was a counsellor available at the practice two days a week as part of the cluster initiative, and a specialist diabetic nurse once every two weeks. In addition, there was a pharmacist who completed medication reviews and Non-Vitamin K antagonist oral anticoagulants annual reviews. There was information on self-referral to services such as physiotherapy available and the practice also had a stop smoking advisor. There appeared to be adequate care navigating through consultations and plentiful resources.

Most patients who completed the questionnaire told us that they 'agreed' or 'strongly agreed' that health promotion material was accessible.

There were initiatives such as 'Compassionate Communities' that the practice engaged in. A dedicated individual would liaise with social services, hospitals and those patients recently discharged from hospital, to enquire as to what support could be offered then work to implement this.

We were told that the practice had organised winter influenza and COVID-19 vaccination clinics for patients which were offered predominantly on a Saturday. However, a Sunday clinic was also implemented to ensure timely completion of the vaccination programmes.

Dignified and respectful care
We observed reception staff welcoming patients in a friendly, professional and courteous manner. All telephone calls received into and made from the practice were done so from the rear office rooms located behind the reception desk area to ensure privacy and confidentiality.

To respect the privacy of patients, there was a dedicated room for private conversations to take place. There were signs on the screens around the reception desk advertising the option for patients to go to a private room to speak if required. If a patient presented in a distressed condition, staff advised they would immediately offer the patient the privacy room.

All bar one of the patient respondents in the HIW questionnaire felt they were treated with dignity and respect, and that measures were taken to protect their privacy.

We saw consultation room doors were kept closed during appointments and privacy curtains and/or locks were used when required to preserve patient dignity. Chaperones were available at the practice and this was very well advertised on posters throughout the practice. Those staff used as chaperones were appropriately trained.

Timely

Timely Care
Patients could access appointments via the telephone or in person at the practice. A call back system was in place to ensure patients did not need to wait in lengthy call queues.

There was not an option to book appointments online, however patients could use the online system to order repeat prescriptions. The practice manager had devised a comprehensive list of presenting complaints including who would predominantly deal with those, to ensure the reception staff were able to triage patients effectively. All staff had also completed care navigation training which enabled patients to be signposted to more appropriate services were necessary.

All patients under the age of 16 would be triaged and seen the same day, in addition to those with mental health conditions or known palliative patients.

Half the patients that completed the questionnaire, answered that they were able to book a same-day appointment when they needed to see a GP urgently. Most patients who answered were content with the type of appointment offered. Half of the patients said they could book routine appointments when needed. The majority of patients who answered felt that they could access the right healthcare at the right time.

Some comments received were:

> *"Impossible to get appointment, by 8.15 all gone, only emergencies left, then you have to prove it's an emergency, always a locum doctor who hasn't read my notes and end up spending the time going through everything again…."*

"Access it is the problem due to travelling to work when the phone lines are open for appointments and then having to leave work early in order to secure an appointment."

"Awful service!!! I need to be on the phone at 8am to get an appointment (more often than not the appointments have gone by the time they get to you on the phone). Very Bad if you haven't got a phone eg. Elderly people as you definitely won't get an appointment any other way…."

There was a dedicated psychological wellbeing worker in the practice two days a week. Staff also knew to signpost to the third sector counselling services where required. There appeared to be communication between secondary care and primary care especially where mental health crisis had been accessed out of hours. A report was provided to the practice with recommendations and actions requiring a follow-up.

We recommend that the practice considers the comments and responses received from patients to improve patient access to appointments and ensure patients can access appointments in a timely manner.

Equitable

Communication and language

The practice described suitable ways of communicating with patients if messages needed to be conveyed or where changes had occurred at the practice. These included face to face, posters on the notice boards at the practice, text messages, website updates and letters. Internal messages to update staff on changes were done through an online communication workflow process.

We checked that documentation would be available in different formats and the practice advised of suitable arrangements for this which included "easy read" documents Bilingual material was available throughout the practice. We were told that if information was required in other languages, apart from English and Welsh, the practice would facilitate this. In addition, if an appointment or verbal messages needed to be relayed in another language, this would be done using the Health Board telephone translation service to assist where there was a communication barrier. However, the practice manager told us that most patients would bring their own translator, for example relatives, or they would use an online translation tool.

There were five patients in the HIW questionnaire responses who told us their preferred language was Welsh. However only one responded to the question confirming that they were actively offered the opportunity to speak Welsh

throughout their patient journey and felt comfortable to use the Welsh language within the surgery regardless of whether they were asked their preference or not.

Where a patient was hard of hearing or deaf and needed to lip read, the practice manager informed us that if personal protective equipment (PPE) was required, the staff would wear clear visors in place of face masks. Noteworthy practice was found whereby alerts on the electronic system indicated hearing or sight issues to inform staff. However, there was no hearing loop installed.

Whilst two of the GPs were Welsh speakers, 'Iaith Gwaith' badges for patients to identify Welsh speakers were not worn.

The practice is required to provide all Welsh speaking staff with 'Iaith Gwaith' badges.

Rights and Equality

There was level access to the practice allowing wheelchair users or those with mobility issues to access the facilities easily. There was ramp access next to the practice that led to a public car park and there were also disability spaces directly outside the practice for those requiring them. The waiting room was spacious and the treatment areas were all situated on the ground floor. Toilets were also wheelchair accessible.

To ensure equality of access, several times a week, GPs would attend home visits. There were also two care homes supported by the lead GP who undertook a ward round every three weeks and acute visits where necessary. We were told that occasionally double appointment slots were booked for those patients requiring extra assistance as well as late afternoon appointments for those who would struggle to attend a morning appointment.

We found that the practice upheld the rights of transgender patients and treated choices in a sensitive manner. Staff confirmed that the electronic system flagged patients preferred pronouns and names, where these differed from their birth name and gender. This was to ensure staff were sensitive to the choices and addressed the patient appropriately.

There was a suitable equality and diversity policy in place and stored on a shared drive. All staff were also in date with their mandatory equality and diversity training.

All patients who answered the question in the HIW questionnaire, indicated that they had not faced discrimination when accessing the practice.

Delivery of Safe and Effective Care

Safe

Risk Management
Treatment rooms at the practice were clean, tidy and clutter free. Sharps bins were in each treatment room, in a safe location. One sharps bin was found to be overfilled, however, this was discussed with the practice and safely removed from the area during the inspection. The area in which clinical waste bins were stored had adequate signage to warn staff, patients and visitors of the relevant hazard.

The practice provided a copy of their Business Continuity Plan. We viewed both the plan created during COVID-19 and the recently renewed version. Both contained the relevant information required. There was an informal "buddying" arrangement in place with a neighbouring practice within the cluster to ensure cover in extreme situations.

The clinical staff at the practice undertook home visits when required. These are suitable risk assessed by the duty doctor.

Discussions were held with the practice manager around significant events and patient safety alerts. These appeared to be dealt with appropriately and up to date policies were in place.

All staff we spoke with were aware of how to urgently call for help if needed. We were shown that a panic button was available on screen for all staff via the patient record software.

During the inspection, we confirmed that an environmental risk assessment, a health and safety risk assessment and an infection prevention and control risk assessment were in place for the practice.

Infection, Prevention, Control (IPC) and Decontamination
Treatment rooms at the practice appeared generally clean and clutter free. Flooring was durable and intact. Both the floor and surfaces were 'wipe clean', allowing for thorough cleaning to take place. Cleaning was arranged by the health board and detailed cleaning schedules were viewed. The privacy curtains in treatment rooms were disposable and recently replaced.

We noted that some measures put in place due to the pandemic had been retained such as the perspex screens on the reception desk and hand sanitisers were available throughout for use by staff, patients and other visitors.

We saw that the practice had an IPC policy in place that had been recently reviewed and was available to all staff. There was no specific IPC lead, the practice manager advised that the lead nurse was responsible for auditing the IPC procedures in place. We reviewed the most recent IPC audit completed by the lead nurse in April 2023. Areas identified for improvement were measurable and actioned accordingly. We also saw evidence of a recently completely healthcare waste audit that was site specific.

A blood borne virus policy was viewed which was considered fit for purpose and there was also a policy in place relating to needlestick injuries. In addition, laminated posters were viewed in all treatment rooms setting out clear steps to take in the event of a needlestick injury.

Sinks in clinical areas had elbow operated taps and all rooms had foot operated bins. All handwashing sinks had signage showing patients, staff and visitors how to adequately wash their hands. All patients who answered the HIW questionnaire said that the practice was either ‘very clean’ or ‘clean’ and that hand sanitizers were available.

Medicines Management
Requests for repeat prescriptions could be made online or in person at the practice in a designated post box. There was a designated pharmacy team working at the practice. The nurse practitioner was also trained in prescribing.

During the inspection we were advised that vaccines delivered to the practice were immediately taken to the nurse for correct storage. The fridge temperature log was viewed and correctly recorded once a day. In the unlikely event of a refrigerator failing, the nurse was able to explain the process and the ‘cold chain’ policy was viewed. Notable practice was seen in this area. Fridges were subject to portable appliance testing, calibrated regularly and alarmed.

Checks on medications and drugs kept on site were undertaken by the nursing team. Whilst checks were being carried out, we did note that some vaccines had passed their expiration date and these were removed from the fridges immediately. Additionally, there were examples of cannulas, bandages, syringes and emergency equipment and drugs that were out of date. This was dealt with under our Immediate Assurance process.

The only controlled drug on site was diazepam for use in an emergency. This was kept on a locked cupboard as required. Appropriate arrangements were in place to ensure prescription pads were stored securely at the practice.

Safeguarding of Children and Adults
We saw evidence of comprehensive safeguarding policies, procedures and training in place at the practice. There were also flow charts in place to assist in identifying an individual at risk. The practice also had a system in place to monitor patients who did not attend appointments and there was a failure to attend policy on the website.

We were advised that staff were able to access the safeguarding team easily. However, we were told that the practice could not engage with health visitors despite repeated attempts and follow ups with the health board relaying the practices' concerns. This could lead to missed opportunities to intervene before a situation escalated.

The practice needs to continue to engage with the health board to ensure that there is a process in place to ensure regular communication between health board employed health visitors and the practice staff as soon as possible.

Staff had undertaken training in safeguarding to level two, based on information initially supplied. However, we were subsequently told that the safeguarding lead had completed training as part of Domestic Abuse training in Clinical Session 1 and Clinical Session 2 which provided Level three safeguarding.

Management of Medical Devices and Equipment
The practice manager stated that the lead nurse at the practice held overall responsibility for checking devices and equipment. However, when speaking to the nursing staff, the named lead nurse stated that they had not been formally assigned the role.

The practice must ensure that staff are aware of their duties and responsibilities and ensure adequate time is allowed within their roles to carry out the duties required.

On the day of our visit, we found that the checking of the emergency equipment was incomplete and that the contents of the emergency equipment could be improved. Checks on the defibrillator were carried out weekly and evidence was provided of completed log sheets for this. However, when we checked the emergency equipment, we noted expired items within the emergency equipment bag. These items included paediatric defibrillator pads, cannulas, syringes, and

airways. In addition, the adult defibrillator pads were stored adjacent to the machine. The layout of the emergency equipment bag could also be improved.

HIW were not assured that the practice had in place a suitably robust system to ensure that expired items were removed from use in a prompt and timely manner. An Immediate Assurance was issued to ensure the practice remove all expired items to ensure these were not used and inadvertently cause patient harm or be ineffective in the event of a lifesaving emergency.

Effective

Effective Care

It was evident that the practice had a caring and dedicated team who provided patients with safe and effective care. There were systems in place for guidelines and best practice to be circulated to relevant members of staff.

Referrals reviewed seemed appropriate. We were advised that the GPs complete their own referrals via the Welsh Clinical Communications Gateway. Referrals that were required by locums were covered in the locum pack to ensure they were not left to other staff members or delayed in any way.

All staff were trained in cardio-pulmonary resuscitation (CPR) and anaphylaxis and compliance was very good. Training was also noted for asthma and hypoglycaemia.

Notable practice was found with reviews of the outcomes of blood results and other relevant reviews. There was a review book held by the nursing staff in addition to the electronic system.

A mental health (MH) worker attended the practice twice a week and the practice triaged those requiring a review. In addition, a psychological well-being practitioner attended the practice regularly. A crisis worker was not based at the practice but could be accessed when required. The triage system was considered a ‘model of best practice’ and provided assurance that referrals to MH services were being managed appropriately.

Patient records

We reviewed a sample of 10 electronic patient medical records. These were stored securely and protected from unauthorised access.

Our review indicated that patient records were mostly clear and maintained to a relatively good standard with historical data and investigation follow ups adequately recorded. However, we found that there was a lack of ‘read codes’ for acute problems. As a result, medications provided for the acute problems, for

example antibiotics for tonsilitis, were not read coded. There was also inconsistent completion of numerical values on certain checks, predominantly when locums were completing records such as temperature or respiratory rate. The record indicated “within normal range”, when a numerical value should be recorded as any decline a patient’s condition needs to be checked against numerical values.

The practice must ensure that there is a consistent approach to record keeping and that necessary read codes and numerical values are entered where required.

Quality of Management and Leadership

Staff feedback

Before our inspection we invited the practice staff to complete an online questionnaire to obtain their views of working for the practice.

From the responses received, two thirds of staff answered that they felt they had the appropriate training to undertake their role. Some answered that there was other training they would find useful. This included training in the following areas:

"Shingles vaccinations"
"Foot checks"
"Organised events with medication companies"

All but one of the respondents answered that they felt able to meet the conflicting demands of their time at work, however all agreed they had the appropriate materials and equipment to carry out their duties, which included access to ICT systems to provide good care and support to patients. All staff agreed there were enough staff members working at the practice to do their job properly and that the skill mix was appropriate.

Two thirds of the respondents indicated that they were involved in decision on changes introduced that affected their work and felt able to make suggestions to improve GP services.

When answering questions on patient care, all staff indicated that patients were able to access GP services in a timely way. All agreed that measures were in place to protect patient privacy and dignity, this included the use of chaperones where required. Staff agreed that health promotion advice was readily available and accessible in various formats. Most respondents felt satisfied with the quality of care and support they give to patients at the practice.

Over half of the respondents were unaware that the practice kept a register of their patients who were carers and similarly, did not know that carers should be offered an assessment of their needs. However, two thirds knew to signpost carers to support organisations where required.

All staff answered that they felt that the practice and working patterns allowed them to have a good work-life balance, and that their job was not detrimental to their health. Whilst most respondents agreed that the practice takes positive action on health and wellbeing of its staff, two respondents disagreed. Just over

half of the respondents were aware that they could access Occupational Health for wellbeing and support.

Staff comments included the following:

> *"Very good working environment with approachable and friendly staff who handle the external pressures of the demand very well."*

> *"All work hard with the resources we have."*

> *"We are all working to our best given the amount of staff that we have within our practice."*

We asked what could be done to improve the service. Comments included the following:

> *"The clinical room could do with a new floor as it is loose and uneven in places."*

> *"Bring back practice meetings so we are all kept up to date on changes that are happening."*

Leadership

Governance and leadership
Abertillery Group Practice was owned and operated by a single-handed GP partner who appeared to be dedicated, committed and enthusiastic about their vision. We found that most staff at the practice were clear about their roles and responsibilities and there were clear lines of accountability. We were told by staff that they felt there were no hierarchical barriers and all views were heard and discussed regardless of position in the practice.

The practice employed several clinical and non-clinical staff, including salaried GPs, nurse practitioners and healthcare support workers. The practice was further supported by a team of administrative staff. The practice manager was passionate about the practice and their dedication was clear. They wanted to ensure, along with the GP partner, that there was a clear plan to continue to meet the growing needs of the population served.

All staff practice meetings were previously held monthly. However, we were advised that due to the new conditions of contract, the practice was finding it extremely difficult to hold whole practice meetings. This was because there was

no protected time for meetings with the requirement to be open between 8am and 6:30pm daily. Smaller group huddles were taking place.

The practice must develop a formal process for team meetings. These should be formally recorded and minutes disseminated to all staff to allow for whole team discussion and information sharing.

The practice had a range of in date policies and procedures in place, which were reviewed annually. Staff had easy access to these via a shared drive. There were two folders in the shared drive for policies and a system in place that automatically moved policies due for review into the second folder to show the reviewer they were due, whilst remaining accessible to staff.

Where information needed to be shared amongst all staff, such as to a policy or procedural change, this was completed through emails with delivery notifications, that was logged on a shared drive. A human resource application (app) software system was being used and through this app, staff would be alerted to changes that required review.

Whilst the practice was not managed by the health board there was support from the health board with the translations and some training. Protected time had been used for training recently.

Workforce

Skilled and enabled workforce
We spoke with various staff at the practice across a range of roles. Most were knowledgeable of their roles and responsibilities and were committed to providing a quality service to patients.

We found some gaps in mandatory training for staff across all clinical and non-clinical roles. We raised this with the practice manager and he assured us that compliance was a key priority and would be dealt with as soon as possible.

The practice must ensure staff are fully compliant with mandatory training.

We reviewed staff records on site and noted that all staff had an appropriate Disclosure Barring Service (DBS) check on file. We were informed that all new starters were required to undertake an appropriate DBS before taking up post. Appropriate job descriptions and contracts of employment were also held on record. We found that the completion rate of personal development plans and annual appraisals was good and the practice manager informed us that this is something that is currently under review to ensure full compliance.

Continuous professional development (CPD) was supported for all staff and the practice manager appeared very keen to support the progression of the workforce. Several staff were undertaking training to advance their skills and knowledge including one practice nurse who had attained a master's in diabetes care and another nurse undertaking a master's in respiratory complaints. We are told this will be invaluable to the practice having these specialisms covered. Administrative staff were also offered support to develop and enhance their skillset.

There was a comprehensive induction package in place for new starters and this also included locums working at the practice.

Culture

People engagement, feedback and learning
There were appropriate processes in place for reporting concerns. These were in line with the Putting Things Right (PTR) processes in the NHS. We viewed a complaints policy and procedure which contained all the relevant information. PTR posters were also clearly displayed in the waiting areas.

The practice complaints folder was reviewed. This contained copies of written complaints and response letters. We saw that complaints were dealt with in a timely manner in line with the policy.

We were told that whilst patient feedback was encouraged, the practice did not appear to have a process to inform patients of the results of this feedback.

The practice must implement a process similar to a 'you said, we did' board to inform patients of the results of the feedback and to encourage patients to continue to participate in practice improvements.

The practice manager understood the new arrangements in place for compliance with the Duty of Candour. The practice had a Duty of Candour policy that met the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2020. This was clear and set out the roles and responsibilities of staff.

We saw evidence that some practice staff had received training on the Duty of Candour and were assured that all staff were aware of how to raise a concern should something go wrong. Whilst this was a new process, discussions with staff confirmed that the staff were aware of their duties.

All staff spoken with advised that they knew how to raise a concern if required and felt comfortable to do so. The practice had a whistleblowing policy in place that had been recently reviewed and this was available to all staff on the shared drive.

Information

Information governance and digital technology
We saw systems in place that ensured the effective collection, sharing and reporting of data and information. We were informed that there was a dedicated Data Protection Officer for the practice through 'Digital Healthcare Wales'.

Datix (for incidents) were reported as necessary and any follow ups were actioned accordingly. The practice was subscribed to a health and safety body who could be contacted for support for incidents as necessary.

The Welsh Clinical Communications Gateway (WCCG) was used by the practice for emailing information such as referrals and reports. Emails sent this way were always acknowledged. Reports from secondary care come via the Welsh Clinical Portal for GPs. These were reviewed in a timely manner.

Learning, improvement and research

Quality improvement activities
We reviewed a selection of clinical audits carried out by the practice, these included the waste management and IPC audits. Both were completed as expected. Staff advised that the practice engaged in activities to continuously attempt to improve care, this included regular audits.

Improvements that were identified from audit activity were discussed and agreed by staff at informal 'huddle' meetings.

We recommend that the practice implements a more formal method for the discussion and dissemination of audit activity and results to allow for whole team learning and improvement.

Whole system approach

Partnership working and development
Staff informed us that various multi-disciplinary meetings took place to ensure effective interaction and engagement with healthcare partners. We were told that the practice worked closely with the GP cluster to build a shared understanding of challenges within the system and the needs of the population.

We were also informed of good arrangements between the practice and secondary care regarding respiratory concerns and diabetes, with qualified nursing staff adequality referring to secondary care services.

4. Next steps

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 how the findings identified will be addressed
- 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
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

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.

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: Abertillery Group Practice

Date of inspection: 12 June 2023

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.

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
During the inspection HIW found prescription medication, specifically multiple boxes of vitamin B12 injections (Hydroxocobalamin 1mg/ml), stored in an unlocked drawer, within an unlocked room. HIW were therefore not fully assured medicines stored at the practice, which should be stored in a lockable cupboard or a lockable fridge, were being suitably stored to reduce the risk of unauthorised access. This poses a potential risk to the safety and wellbeing of	Implement and maintain a robust medicines management procedure to ensure that all medication held at the practice is done so in a safe, secure and effective manner that prevents access to and removal by unauthorised persons.	Updated our medicines storage policy to reflect improvement needed along with addition of a medication log for clinicians to keep record.	Sharon Duggan, Practice Pharmacist	Completed and in place from 19.06.2023

patients and other individuals who may access and ingest medication not meant for them.				
During the inspection HIW found expired items present within the emergency equipment bag and some clinical areas that had not been removed from use. Expired items included: • Paediatric defibrillator pads • Oxygen cylinder • Airways • Needles • Cannulas • Syringes • Bandages • Vaccinations HIW were not assured that the practice had in place a suitably robust system to ensure that expired items including sterile items and medications, were	Ensure all expired items are removed from the clinical rooms and disposed of in an appropriate manner Develop, implement and maintain a robust system for the management of sterile materials	Stock check of all items with emergency cupboard and bag. Appropriately disposed of all out-of-date items. Developed and implemented a robust system for management of all sterile and emergency materials. This is managed through a shared drive to access, update, save, and print the log monthly. Each log is to be saved as the corresponding month and year (e.g. June23, July23). This list is to be printed and placed within emergency cupboard for monthly reference and used to alert when items are required to be replaced.	Practice Nurse team (Kerry Owen and Nicola Heal-Williams) and Healthcare Assistant (Belinda Waite) Management Team (Joe Moreno, Rhiann Mainwaring, and Kelly Devine)	Completed on 16.06.2023 Completed on 15.06.2023

removed from use in a prompt and timely manner. Failure to remove expired items may mean that they could be used by a clinician and cause patient harm or be ineffective in the event of a lifesaving emergency.	Ensure that the check of the emergency equipment includes checking dates of the contents of the bag.	Developed a monthly stock check of emergency equipment items along with log.	Practice Nurse team (Kerry Owen and Nicola Heal-Williams)	Completed on 20.06.2023

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): **Joe Moreno**

Job role: **Practice Manager**

Date: **20 June 2023**

Appendix C - Improvement plan

Service: Abertillery Group Practice

Date of inspection: 12 June 2023

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.

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
A number of comments were made by patients relating to lack of patient access to appointments.	We recommend that the practice considers the comments and responses received from patients to improve patient access to appointments and ensure patients can access appointments in a timely manner.	Revising phone message to reflect better messaging. Review of eligible pre-bookable appointments. Restructure clinics for specific days and times for pre-bookable appointments. Better messaging to registered patients regarding expectation within limitation of capacity and workforce.	Joe Moreno, Practice Manager	Phone message and patient messaging initial review – 30.08.2023. Main Call-Flow update phone message and messaging campaign – 06.11.2023 Review changes 31.12.2023 Review pre-bookable

		Request to read full range of comments made to better understand view. Based on recent GP Experience Survey completed by patients in December 2022, 68% stated they are waiting shorter than expected or about the right amount of time. 22% stating a bit too long and 9% stating much too long. In order to appropriately capture views, we will be participating in another survey end of the year along with our NCN.		appointments and defining clinics – 09.08.2023 Submit Version 1 pre-bookable appointment options – 09.10.2023 Review options – w/c 09.10.2023 Implementation of any changes – 06.11.2023 Review changes 31.12.2023
Three staff members at the practice were Welsh speaking, however none wore 'Iaith Gwaith' badges to inform patients of this.	The practice is required to provide all Welsh speaking staff with 'Iaith Gwaith' badges.	Badges provided to all members of staff which are Welsh speaking	Joe Moreno, Practice Manager	Completed
We noted that the practice had attempted to engage with the	The practice needs to continue to engage with the health board to	Had our initial meeting with health visitors on 21.06.2023	Dr J Rudling, Safeguarding	Ongoing – dates in action

health board regarding concerns around lack of communication with health board health visitors as this could lead to missed opportunities to intervene before a situation escalated. All attempts had failed.	ensure regular communication between health board employed health visitors and the practice staff as soon as possible.	Future meetings scheduled (next meeting 09.08.2023). Further meeting with Adult safeguarding 02.08.2023 to discuss further engagement and collaboration.	Lead and Joe Moreno, Practice Manager	
During discussions with the lead nurse, we were advised they were unaware they were considered the lead nurse, as they had not been formally appointed to the role.	The practice must ensure that staff are aware of their duties and responsibilities and also ensure adequate time is allowed within their roles to carry out the duties required.	Employee handbook provided to all staff, updated policies and procedures placed on shared drive and given to appropriate staff outlining roles and responsibilities.	Management Team	Completed
Our review of patients records showed most were to a good standard with historical data and investigation follow ups recorded. However, we found a lack of read codes for acute problems. Additionally, there was an inconsistent completion of numerical values on certain checks, such as temperature or respiratory rate. Instead,	The practice must ensure that there is a consistent approach to record keeping and that necessary read codes and numerical values are entered where required.	Dr Rudling spoke with the locum GP this portion of the action highlighted. Currently considering changing GP systems as other system provides a more organised display for GP's and other clinical roles to utilise. Participating in mini competition of GP systems	Dr Rudling and Management Team	21.07.2023 And 20.10.2023

“within normal range” was recorded. This was predominantly when locums had completed records.		and submitting evaluation toolkit in October 2023.		
We noted that whilst the practice held smaller group huddles and shared information through various means, the all-staff practice meetings had not been taking place.	The practice must develop a formal process for team meetings. These should be formally recorded and minutes disseminated to all staff to allow for whole team discussion and information sharing	GP meeting held out of hours with quarterly meetings scheduled along with minutes. Clinical meeting organised for with bimonthly time slot rotating Tuesday, Wednesday, and Thursday to ensure we capture various working time patterns. Practice meeting planned for September	Dr J Rudling, GP Lead and Joe Moreno, Practice Manager	GP meeting 15.06.2023 (next meeting 28.09.2023, TBC) Clinical meeting 17.08.2023 (next meeting 17.10.2023, TBC)
The review of staff records highlighted several gaps in mandatory training for both clinical and non-clinical staff.	The practice must ensure staff are fully compliant with mandatory training.	Staff training matrix spreadsheet has been updated with alerts and reminders notifying when training is upcoming and/or overdue.	Management Team	Completed
The practice did not have a method in place to display	The practice must implement a process similar to a ‘you said, we	Placed a whiteboard in waiting room. Will use this	Management Team	01.09.2023

improvements made to the practice as a result of patient feedback.	did' board to inform patients of the results of feedback and to encourage patients to continue to participate in practice improvements.	board to provide action points from patient feedback.		

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): Joe Moreno

Job role: Practice Manager

Date: 08.08.2023