Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Practice Inspection Report (Announced)

Nantgarw Road Medical Practice, Aneurin Bevan University Health Board

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Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales
Website: www.hiw.org.uk

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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 Nantgarw Road Medical Practice, Aneurin Bevan University Health Board on 12 July 2023.

Our team for the inspection comprised of a HIW Healthcare Inspector, 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 19 questionnaires were completed by patients or their carers. 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 Nantgarw Road Medical Practice was committed to providing a positive experience for its patients. Patient responses received through HIW questionnaires were generally positive, with respondents rating the service as 'good' or 'very good'.

There was a good supply of health promotion information available and on display to patients. There was level access to the practice enabling wheelchair users or those with reduced mobility to access the facilities easily. The waiting room was spacious and the treatment areas were all situated on the ground floor. There was also an area for children in the waiting room.

Consultation and treatment rooms were located away from the main reception area and all allowed for privacy and dignity to be preserved.

Processes were in place to attempt to reduce the waiting times for patients contacting the practice by telephone and we found access to appointments was good.

Chaperones were used where required, this service was well advertised throughout the practice and most patients stated they had been offered chaperones where appropriate.

This is what the service did well:

- Welsh speaking staff wore 'Iaith Gwaith' lanyards to indicate they were Welsh speaking
- Good supply of health promotion materials
- Level access for patients with mobility issues.

Delivery of Safe and Effective Care

Overall summary:
We found the staff team were dedicated and committed to providing patients with safe and effective care in an environment that was clean, tidy and free of clutter. Consultation and clinical rooms were of good size and well equipped.

Medical records were found to be generally of a good standard. However, whilst areas of good practice were noted, we did identify a small number of issues in

relation to linking medication to diagnosis and also including the type of consultation that took place.

Additionally, we found items which were out of date in the emergency bag and vaccines in the incorrect fridge. These were dealt with immediately on site.

This is what we recommend the service can improve:

- Checks of emergency equipment to include dates of items in the emergency bag
- Infection prevention and control audits to be completed
- Medical records should reflect type of consultation carried out.

This is what the service did well:

- Referrals to other services
- Medication reviews process
- All areas within the practice were clean, well maintained and clutter free.

Quality of Management and Leadership

Overall summary:
We found the practice had 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 training opportunities to fulfil their professional obligations and career advancement.

There was evidence of a comprehensive induction process, with good compliance to staff recruitment procedures. Our review of mandatory training compliance found this to be good overall with some gaps present.

The practice had comprehensive and up to date policies and procedures.

Team meetings were taking place with the relevant team leads. Practice and cluster wide meetings were also taking place regularly and feedback via minutes for those absent.

This is what we recommend the service can improve:

- Staff compliance with mandatory training.

This is what the service did well:

- Regular appraisals for all staff
- Good access to training opportunities

- Up to date policies and procedures.

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:

> *"The doctor was lovely. Understanding, patient and kind."*

> *"[Dr] and [Dr] are outstanding doctors at the practice - exemplary practise. [HCA] also exemplary and very efficient and thorough. However, the rest of the service leads a lot to be desired. Many locum doctors. [Dr] makes errors and does not diagnose quickly enough which leads to complications (happened twice to myself) and the practice manager is very dismissive and difficult to get hold of in person[1]. Very long waits on the telephone to get an appointment on the day but worse to get regular appointments and can wait weeks upon weeks. Bloods I had to wait two weeks for."*

Person centred

Health Promotion

During our inspection we were shown a variety of health promotion information available to patients on the practice website and social media platforms. We also saw that the practice had a good supply of health promotion information available to patients, displayed on dedicated noticeboards in the reception area. There was also a television in the reception area displaying health promotion information on a loop.

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[1] In reply the practice manager stated that "there may be times that I am not immediately available to patients, such as leave, when I am in meetings, or during high demand periods – But I always return contact to patients , or at least ask my deputy to deal with the matter if they ask to speak to me, or I send on a complaints procedure should they wish to make a complaint."

There was a mental health practitioner at the practice, alongside a counsellor and a physiotherapist. There appeared to be adequate care navigating through consultations and plentiful resources available to print at the time of consultation.

Over two thirds of the patients in the questionnaire agreed there was health promotion and patient information material on display.

Dignified and respectful care
We observed reception staff welcoming patients in a friendly, courteous and professional manner. There was a dedicated room for private conversations to take place, to respect the privacy of patients. Telephone calls received into and made from the practice were done from offices located away from the reception area to ensure privacy and confidentiality was maintained at all times.

Consultation and treatment rooms were located away from the main waiting area and well laid out. We saw that all consultation room doors were lockable and privacy curtains available around each bed to preserve patient dignity.

Chaperones were available and this was well advertised on posters throughout the practice. We were told that when patients telephoned for an appointment and staff were able to identify that a chaperone may be required, patients were offered this ahead of the appointment and again prior to examination. Staff members who provided chaperone assistance were appropriately trained through the e-learning provided by NHS Wales. When staff were questioned about providing chaperone assistance, they were able to correctly discuss their role in the process.

Over half of patients believed that they could not talk to reception staff without being overheard, most stated that measures were taken to protect their privacy. In addition, most patients stated that they had been offered chaperones where appropriate.

The practice manager stated that patients who walk in who need medical help are asked to complete a form to detail what is needed where possible with confidentiality in mind, therefore patient will not need to tell the receptionist details in front of others.

Timely

Timely Care
The arrangements for patients to access services was described. Patients could access appointments via the telephone or in person at the practice on the day or in advance. Notices were displayed in the waiting room to advise of any delays.

Patients were also contacted via text message, the practice website and the practice social media page.

The practice had an access policy that was based on the requirements of the access standards. All staff had completed care navigation training which enabled patients to be signposted to more appropriate services were necessary. Staff had access to a triage template to obtain information to assist in this. All patients with mental health conditions or those under the age of 16 would be triaged and seen the same day.

The majority of patients that completed the questionnaire answered that they were able to book a same-day appointment when they needed to see a general practitioner (GP) urgently. Half of these patients answered that they were offered the option to choose the type of appointment they preferred (in person, virtual video-link, telephone) and the majority were content with the type of appointment offered. Three quarters of patients said they could book routine appointments when needed.

Some comments received were:

> *"Can't always get an appointment for a few weeks."*
>
> *"I felt awful but 10 day wait for palpitation's".*

We saw evidence of good communication between secondary care and primary care especially where mental health crisis had been accessed out of hours. Signposting and referrals were also made to services such as physiotherapy, accident and emergency, opticians and dental practices.

Equitable

Communication and language
We reviewed how information from secondary care was recorded and acted upon. We found that this information was collated by the administrative staff who would scan documents received in hard copy. All incoming mail was linked to patients' records. Any diagnosis was added to patient notes and Read coded. These would be sent electronically to GP if an action was required or any changes to medication. No significant backlog was noted.

The practice described suitable ways of communicating with patients if messages needed to be conveyed. These included website updates, social media, telephone, secure 'push' messages via the app and face to face. All patient's incoming calls were recorded. There were daily message lists for queries to be dealt with or

reviewed by the duty doctor. We were shown that housebound patients were Read coded in patients records and where these patients required a home visit, a pop-up box would appear on screen and suitably booked. Where a patient was not housebound, a home visit request was added to the triage list. Patients with additional needs were captured on registration, or upon receipt of a diagnosis and the system flagged to warn staff that additional support may be required.

We checked that documentation would be available in different formats and the practice advised of suitable arrangements. This included a configurable website for text size, "easy read" documents, braille signage and also bilingual material, in Welsh and English, 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. One of the practice GPs was fluent in British sign language (BSL) so this was also used where required. However, the practice manager told us that patients requiring BSL would often bring their own translator, for example relatives.

There were some Welsh speaking staff at the practice. These staff members wore 'Iaith Gwaith' lanyards to indicate they were Welsh speakers. We viewed the system that automatically assigned the Welsh speaking patients to a Welsh speaking doctor in the first instance, then changed if that doctor was unavailable.

Rights and Equality

There was a suitable equality and diversity policy in place and stored on a shared drive. There was also a practice statement on inclusivity. All staff were also in-date with their mandatory equality and diversity training. We were told that the practice engaged with and contributed to the local cluster on tackling health inequalities and improving access to health improvement initiatives. We saw that the practice was an equal opportunities employer.

The practice offered good access with a free car park. There was level access to the practice allowing wheelchair users or those with impaired mobility to access the building easily. The waiting room was spacious and the treatment areas were all situated on the ground floor. Toilets were also wheelchair accessible.

Staff spoken with understood their roles in ensuring all patients and colleagues were protected from discrimination. We were shown evidence of risk assessments and reasonable adjustments that had been put in place.

We found that the practice upheld the rights of transgender patients and treated choices in a sensitive manner. We saw evidence that the electronic system had warning 'pop ups' to flag a patients' pronouns and preferred names, where these differed from their birth name and gender.

Many of the respondents who answered felt that they could access the right healthcare at the right time (9/13). All patients who answered the question in the HIW questionnaire, indicated that they had not faced discrimination when accessing the practice.

When asked a series of questions in the survey, all patients agreed that:

- They felt listened to
- They were treated with dignity and respect
- They were involved in decisions about their healthcare as much as they wanted to be
- They were offered healthy lifestyle advice.

Delivery of Safe and Effective Care

Safe

Risk Management
We found the practice premises to be generally clean, tidy and free from clutter. In treatment rooms, we saw that sharps bins were in a safe location. However, one sharps bin was found to be full and had been in use for some time. This was discussed with the nurse and safely removed 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.

During the inspection, we viewed up to date environmental risk assessments and a health and safety risk assessment.

We were also provided with the practice Business Continuity Plan. This had been reviewed and recently implemented when there had been a loss of phone lines and electricity at the practice. Whilst it is impossible to plan for every scenario, the plan appeared to contain the necessary details to ensure appropriate action was taken in the event of an unforeseen incident. There was an informal "buddying" arrangement in place with a neighbouring practice within the cluster to ensure cover in extreme situations.

Discussions with senior staff demonstrated that significant events and patient safety alerts were dealt with appropriately and we were provided with policies for both that had been reviewed recently.

Staff we spoke with were able to describe the process to follow should they need to urgently call for help. We were shown that a panic button was available on screen for all staff via the patient record software.

Infection Prevention and Control (IPC)
Several clinical rooms were inspected at the practice. These appeared generally clean and clutter free, and flooring was durable and intact. Both the floor and surfaces were 'wipe clean', allowing for thorough cleaning to take place. All rooms had foot operated bins and all clinical rooms had elbow operated taps. All handwashing sinks had adequate signage showing patients, staff and visitors how to wash their hands.

All cleaners were contracted, and all were aware of their responsibilities. Detailed cleaning schedules were viewed, these included deep cleaning, water testing and completed sign off sheets.

We noted that privacy curtains in clinical rooms were fabric and not disposable. We were told that cleaning of these took place in a staff members' domestic washing machine. However, we were advised that all recommended heat settings for the cleaning of fabric curtains in clinical settings were being followed.

We recommend that the practice considers changing the fabric privacy curtains to disposable curtains. Alternatively, the practice must include the process for cleaning fabric curtains in their IPC policy. We also recommend that a record is kept of when the curtains were last laundered and the temperature at which they were laundered should also be completed and retained.

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.

The practice provided us with a copy of their IPC policy. We noted this had been recently reviewed and was available to all staff. We requested sight of the most recent IPC audits completed by the practice. We were advised these had not been completed for some time.

The practice must ensure IPC audits are carried out monthly and any areas identified for improvements are measurable and actioned accordingly.

We noted that PPE was readily available, and that certain measures put in place during the pandemic had been retained such as the Perspex screens on the reception desk and hand sanitisers available throughout the building. Those patients who completed the questionnaire and attended in-person appointments, said that the GP Practice was either ‘very clean’ or ‘clean’ and that hand sanitisers were available.

Medicines Management
Requests for repeat prescriptions could be made via My Health Online, the practice’s mobile app, or in person at the practice with a 72-hour turnaround time. Notable good practice was found in this area. Where patients required a review or had their maximum amount of repeat prescriptions, the practice would notify patients that a review was due by sending a text message which included a link to enable the patient to access specific bookable appointment slots for the review to take place. There was a designated pharmacist at the practice, alongside nurse prescribers and GPs, so reviews were booked with the most relevant clinician depending on condition and medication.

Medications that were no longer being taken by patients would be removed from the repeat prescribing list. There was an audit of patients not requesting medications for more than 18 months and then the relevant item would be removed where appropriate.

There were arrangements in place for the safe storage of drugs at the required temperature, with refrigerated storage where necessary. Logs showing that fridge temperatures were being recorded once a day were viewed. During the inspection we were advised that vaccines delivered to the practice were immediately taken to the nursing team for correct storage. The nurse was able to explain the processes in place in the unlikely event of a refrigerator failing. A 'cold chain' policy was also viewed, this contained the required information.

Checks on medications kept on site were undertaken by the nursing team. Whilst checks were being carried out, we did note some vaccines had passed their expiration date in one fridge and we also found in date vaccines being stored in a specimen fridge. These were removed from the fridges immediately. Additionally, there were vaccines being stored loose, mixed, and not in their original packaging. Fridges were subject to portable appliance testing, calibrated regularly and alarmed.

The practice must ensure vaccines are appropriately stored and in their original packaging.

Arrangements were in place to ensure manual prescription pads were stored securely at the practice in lockable cupboards. Each morning administrative staff would 'top-up' prescription trays in printers so clinicians should not run out during the day. This ensured there was less need for prescription pads to be held outside the locked cupboards.

Safeguarding of Children and Adults

The policies, procedures and culture at the practice ensured that patients and staff were able to report safeguarding concerns. This included ensuring that safeguarding issues were appropriately investigated and action taken where necessary to protect the welfare of vulnerable children and adults. We saw evidence of comprehensive safeguarding policies, procedures and training in place at the practice. Clinical staff had undertaken training in safeguarding to level three, this included the safeguarding lead. Admin staff were trained at level two. We were advised that staff were able to access the safeguarding team easily.

Records were Read coded where a patient was on the child protection register or a looked after child, and these were followed up accordingly. A named doctor at the practice received all correspondence related to child protection matters.

We found good arrangements in place to follow up on emergency department attendance and those who did not attend (DNA) appointments, both at the practice and hospital appointments. Those patients would have the DNA recorded by a Read code in the patient notes and this meant they could be searched on the system. This would be Read coded on the system. Where a patient was under the age of 16, they would be immediately referred to the GP, otherwise a text message would be sent to the patient, followed by a letter. There was a policy in place where if a patient did not attend twice in six months a meeting would be called with the patient. Where a patient was taking prescription medication and the prescribing team issue a "last issued" text reminder and a patient fails to attend, the prescribing team would phone the patient to make a new appointment.

We were told that messages from allied health professionals would be given to the duty doctor. There was good engagement, including monthly meetings with the health visitors and bi-monthly meetings around palliative care held at the practice or virtually where required.

Management of Medical Devices and Equipment
All clinical staff were responsible for checking medical devices and equipment daily, with electrical equipment having annual portable appliance testing and calibration annually. There were calibration logs and stickers on individual pieces of equipment, with an annual contract in place. We were told that each GP maintained their own clinical bag for off-site patient visits.

Checks on the emergency equipment were being undertaken by the clinical staff. However, we found that the contents of the emergency bag could be improved as we found the Glucogel and rectal diazepam were out of date. There was an automatic external defibrillator (AED) available with age-appropriate pads. However, we found all pads were also out of date. The adult defibrillator pads were replaced during our inspection and the paediatric pads were ordered. The out-of-date items were immediately removed from use.

The practice must ensure there are sufficient processes in place to check equipment levels within the emergency equipment bag and the expiration dates of this equipment.

Effective

Effective Care
It was evident that the practice had a caring and dedicated team who provided patients with safe and effective care. The methods used by the practice to keep

up to date with national and professional guidance, and best practice were explained. This included discussions during annual appraisals, revalidation, e-learning, in-house teaching, and mandatory training.

The process used for referrals was described; urgent referrals would be referred through the Welsh Clinical Communications Gateway (WCCG) except for locum doctors who would add consultation notes and refer to administrative staff for uploading to WCCG. Routine referrals would also be completed in the same manner as the urgent referrals by the referring clinician. Notable practice was found with the systems in place for checking urgent suspected cancer referrals had been acted on in a timely manner. Referral updates were forwarded to the relevant doctor, so they were aware if the referral status changed from routine to urgent and vice versa.

Datix was used to report incidents and staff had received training on how to use the system.

All staff were trained in cardio-pulmonary resuscitation (CPR) and anaphylaxis.

A number of services were provided by or within the practice. These included a counsellor and mental health worker, physiotherapy and access to wellbeing services.

Patient records
We reviewed a sample of 10 electronic patient medical records and multiple consultations for each, drawn from the appointment booking system six weeks prior to the inspection. The overall quality of patient medical records was very good. There were comprehensive records with clear recording of history, examinations, investigations, and planned treatment, with evidence of the use of diagnostic Read codes. However, we found a couple of episodes where the type of consultation appeared to be surgery attendance but were actually telephone consultations.

The practice must ensure that patient records clearly identify which type of consultation took place.

Conversely there were instances of excellent safety netting and use of patient information leaflets issued by the system electronically. We noted that on occasions medications were not always linked to conditions on the ‘link medication’ screen. Also, the reason for stopping medications was not always listed in the ‘past medication' screen.

The practice must ensure that medication is linked to specific diagnoses and issues in patient medical records.

There was secure storage and compliance with the Data Protection Act 1998 and General Data Protection Regulations (GDPR) in so far as records were concerned. However, we were advised that call recordings were kept indefinitely.

The practice must ensure that call recordings follow GDPR guidance and should be kept only for as long as needed.

Quality of Management and Leadership

Leadership

Governance and leadership
There were clear operational systems and processes in place to support effective governance, leadership and accountability at the practice. We found that staff were clear about their roles and responsibilities, we viewed a sample of job descriptions. We were told these were reviewed at appraisals and any changes would be agreed there, including title changes. We were given an example where the nurse had become a prescriber following development and training, this was reflected accordingly.

Various meetings took place at the practice, this included a partner business meeting every fortnight and admin meetings held monthly. Multidisciplinary team meetings were held, all doctors would be present for these, sometimes online if required. Whole team meetings also took place, where changes would be discussed, such as new cancers, palliative reviews, safeguarding, health visitors, and district nurses. These were themed where possible and guest speakers were often invited. We were advised clinical meetings took place on rolling days to ensure all staff had the same opportunities with guest speakers attending. All meetings were minuted and shared with staff via email and an online group, where staff had to acknowledge to advise they had read and understood.

The practice had a range of in date policies and procedures in place, which were reviewed annually. These were clear, named and dated for review. Staff had easy access to these via a shared drive and in hard copy in the practice managers office. The practice manager held a review schedule and it was evident that this was adhered to.

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, on the online group chat requiring acknowledgement. These were then stored, on the shared drive and updated on the practice website where applicable. If information needed to be shared with patients, this was through an application, text messages, posters in the reception area and practice website.

Whilst the practice was not managed by the health board there was good support from the health board. This included accessing the occupational health department for wellbeing and mental health support. Translation support and training were also accessible via the health board. We were told that protected time was being used for recent training.

The practice manager believed that the main challenges and pressures being faced by the practice had been sustainability. There were two doctors on maternity leave, sessions for which were only partially covered by a locum. The practice advised they needed to utilise locums more than they would have liked. However, a new salaried GP had just been recruited and the practice were in talks with another doctor to carry out additional sessions. The hope was that with the return of one of the doctors from maternity leave, this would alleviate some issues.

The practice had leads in specific areas, including a National Care Network (NCN) lead who attended NCN meetings. There was also a lead for geriatric patients and other leads for safeguarding. The safeguarding leads were also trainers. We were advised the newest GP partner wanted to be put through the programme. There were also two specific GPs who carried out minor ops, with no cutting involved. We were told that all staff worked within their scope of practice.

Workforce

Skilled and enabled workforce

We were shown the induction timetable which had been set out by one of the partners. We were also shown the full induction programme in place for new starters, this also included locums working at the practice. The administration and clinical induction had been separated out and adapted accordingly. All mandatory training was listed to be carried out over a four-week period, followed by a training needs analysis at a one-month review. There would also be a five-month review, sooner if required. All staff were provided with a staff handbook and a confidentiality undertaking was signed. There was also a registrar/locum handbook available. Shadowing was mostly carried out over a fortnight, but this was tailored to an individual and extended if required.

We spoke with various staff at the practice across a range of roles. All were knowledgeable of their roles and responsibilities, lines of accountability and seemed committed to providing a quality service to patients.

We reviewed a sample of staff personnel files and these showed that all staff had an appropriate Disclosure Barring Service (DBS) check completed and references were sought ahead of taking up post. Comprehensive job descriptions and contracts of employment were also held on record. The central register of the Hepatitis B status of staff and the system for monitoring all relevant clinicians was up to date. Completion rate of personal development plans and annual appraisals was very good. This was above ninety percent.

Nursing staff spoken with advised they have access to continuous professional development (CPD) and this was being supported. The practice manager also supported the progression of the entire workforce. Several staff were undertaking training to advance their skills and knowledge including one practice nurse who had become a prescriber and another nurse who had undertaken training to lead in areas such as respiratory complaints and wound care and now ran a specialist would care clinic. Administrative staff were also offered support to develop and enhance their skillset. We were told there was a particular push for upskilling when an additional 1000 patients were transferred from the closure of a neighbouring practice recently.

When viewing the records for mandatory training, we found that staff were mostly compliant. This included all staff completion of Basic Life Support (BLS) / Cardiopulmonary Resuscitation (CPR) training in January 2023 which took place as a group. We were advised that where someone is brought in to carry out whole staff training and where a staff member is absent, the expectation is for those staff to source their own training as soon as possible for full compliance. We noted that whilst in-house training in Equality, Diversity and Rights was offered, there were low levels of completion. Additionally, many staff were out of compliance with IPC training.

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

Culture

People engagement, feedback and learning
Staff we spoke with said that the partners and the managers at the practice were visible, approachable and 'hands on'. There was clearly a diverse workforce that included different races, culture, and disabilities. We were informed that the practice valued this inclusive culture and that differences were valued at all levels of the organisation.

All staff spoken with said they were encouraged to speak up when they had new ideas or concerns and felt comfortable to do so. There was a suggestions box in place and there was a standing agenda item in the practice meetings to discuss anything raised. The practice also had a whistleblowing policy in place that had been recently reviewed and this was available to all staff on a shared drive.

There were appropriate processes in place for reporting concerns, in line with the Putting Things Right (PTR) processes in the NHS. We viewed a complaints policy and procedure which was in date and included reference to HIW. The procedure

also included timescales and reference to Llais and advocacy support services. PTR posters were also clearly displayed in the waiting areas.

The practice complaints were reviewed. From this, we saw that complaints were dealt with in a timely manner in line with the policy. The practice also held a complaint register which contained clear information on the type of complaint, who was responsible for leading, investigating and responding to complainants, what actions were taken, and lessons learned. This register was stored on a shared drive and discussed at specific meetings to review the complaint and to share learning from completed complaints.

The practice manager understood the new arrangements in place for compliance with the new 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. There was also an 'easy read' procedure flow chart for staff. We saw evidence that practice staff had received training on the Duty of Candour and were assured that staff were aware of how to raise a concern should something go wrong. Whilst this was a new process, discussions with clinical staff confirmed awareness of their duties.

We were told that patient feedback was encouraged and suggestions could be made in person or via the joint prescription/suggestion box in reception. The practice also carried out patient questionnaires and there was information on the practice website about how to feedback, complain, or raise concerns. Actions arising from feedback were shared regularly on social media platforms, where there was also a lot of information and updates such as telephone demands or issues with the phone lines. Push notifications were also used through the application and could be used for a multitude of purposes including calls for flu vaccinations.

Where required, the practice had the ability to listen to phone calls to check for the attitude of staff. During the appraisal process a sample of calls were listened to and this had led to e-learning modules required for some staff on dealing with difficult patients. The concerns process was also routinely audited for improvements.

Where relevant, feedback or complaints would be discussed in cluster meetings, particularly around any significant events and lessons learned.

Information

Information governance and digital technology

We saw systems in place that ensured the effective collection, sharing and reporting of data and information. There were various policies and procedures in place including a Fair Usage policy, Freedom of Information, Closed circuit television (CCTV), and GDPR. An audit system extracted anonymous data for surveillance to ensure data was accurate, valid and reliable. The WCCG system was used for 95% of referrals, the other 5% were mental health referred directly in a secure portal and encrypted, or secure file transfer when necessary, such as to Social Services. Datix were reported as necessary, and any follow ups were actioned accordingly.

We were informed that there was a dedicated Data Protection Officer for the practice and that appropriate training had been completed by staff around collection, storage, and protection of data.

Learning, improvement and research

Quality improvement activities
Staff advised that the practice engaged in activities to continuously attempt to improve care, this included regular audits. Performance was being measured and reported appropriately. There had been a statutory requirement for monthly reporting of activity data, a workforce system to monitor staff changes and telephony activity reported as part of the Quality Assurance and Improvement Framework (QAIF). There was also a Primary Care Information Portal dashboard which was being checked once a month and DNA rates then shared with patients.

We requested to view a selection of clinical audits carried out by the practice. We were provided with the waste management audit, which was completed and actions to take, were clear and appropriately timed. Improvements that were identified from audit activity were discussed and agreed by staff at practice meetings. Significant events analysis was completed and the results cascaded to the team. Learning was also shared with the cluster and Health Board where relevant.

Whole system approach

Partnership working and development
The practice was one of the GP practices in the Caerphilly Health Cluster, located on the Aneurin Bevan University Health Board area. Staff informed us that the practice worked collaboratively with other healthcare providers within the cluster. Various multi-disciplinary meetings took place to ensure effective interaction and engagement with healthcare partners. We were also informed of good arrangements between the practice and secondary care, and third sector organisations.

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
During the inspection HIW found expired items present within the emergency bag that had not been removed from use. These included defibrillator pads, diazepam and Glucogel.	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.	HIW escalated the issue to the nursing team to ensure all expired items were removed from the emergency bag and disposed of in an appropriate manner.	Adult defibrillator pads were replaced during the inspection. All other items were ordered immediately.

Appendix B - Immediate improvement plan

Service: Nantgarw Road Medical Centre

Date of inspection: 12 July 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
No immediate assurance issues were identified.				

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

Service representative:

Name (print):

Job role:

Date:

Appendix C - Improvement plan

Service: Nantgarw Road Medical Centre

Date of inspection: 12 July 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
We noted that privacy curtains in clinical rooms were fabric and not disposable. We were told that cleaning of such took place in a staff members' domestic washing machine.	We recommend that the practice considers changing the fabric privacy curtains to disposable curtains. Alternatively, the practice must include the process for cleaning fabric curtains in their IPC policy. We also recommend that a record is kept of when the curtains were last laundered and the temperature at which they were laundered should also be completed and retained.	(1) IPC inspection checklist and policy to be amended to include specific mention of privacy curtains as per national standards of healthcare cleanliness. (2) Cleaner checklists to include a scheduled dates for rotation cleaning of fabric curtains – to be signed off by cleaner, temperatures noted of	Andrew Langley	1 month

		clean as per recommendations. (3) Deep clean schedule and IPC inspections to include visual inspection of curtains hoovering / dusting of curtains in between machine washes – In event of staining curtains will be removed and cleaned ahead of schedule.		
We requested sight of the most recent Infection, Prevention and Control (IPC) audit completed by the practice. We were advised these had not been completed for some time.	The practice must ensure IPC audits are carried out monthly and any areas identified for improvements are measurable and actioned accordingly.	(1) IPC audit review checklist revised and updated in line with coronavirus updates 2022 (2) Clear responsibilities for audit personnel , frequency of systematic check specified in document and diarised	Andrew Langley/Jan Ryzy/Penny Robins	1 month

Whilst checking refrigerators at the practice we found there were vaccines being stored loose, mixed, and not in their original packaging	The practice must ensure vaccines are appropriately stored and in their original packaging.	(1) Clear guidance to nursing team given as part of action plan (2) Spot checks as part of IPC audits	Jan Ryzy/Andrew Langley Jan Ryzy / Andrew Langley/ Penny Robins	By end September Monthly
When checking the emergency bag, we found items that were out of date. These included defibrillator pads, diazepam and Glucogel. Some items were replaced during the inspection, and others ordered immediately.	The practice must ensure there are sufficient processes in place to check equipment levels within the emergency equipment bag and the expiration dates of this equipment.	(1) Review of current systems for checks, named staff, ensuring deputy 'buddy' arrangements for leave, and overall lines of responsibility (2) Spot checks as part of IPC audit	Jan Ryzy / Andrew Langley Jan Ryzy / Andrew Langley / Penny Robins	1 Month Monthly
When checking patient records, we found a couple of episodes where the type of consultation appeared to be a surgery	The practice must ensure that patient records clearly identify which type of consultation took place.	(1) All clinicians to be reminded over recording of accurate basic consultation data,	Andrew Langley/Penny Robins	2 weeks

attendance but were telephone consultations.		'How to' information made available for new staff/Locums with step by step images (2) Baseline search of current consultations where appointment indicates 'house visit' or 'telephone call' where episode is recorded as 'Seen in surgery'. Reaudit after 2 months to ensure compliance – Discuss any ongoing issues with individuals if trend. (3) Discuss in organisational meeting	Andrew Langley	1 month 1 month
When checking patient records, we noted that on occasions medications were not always linked to conditions on the 'link medication' screen.	The practice must ensure that medication is linked to specific diagnoses and issues in patient medical records.	(1) Reminder to all clinicians electronically (2) Discuss in clinical meeting	Andrew Langley Clinical team	2 weeks October meeting

		(3) 'How to' information made available for new staff/Locums with step by step images	Andrew Langley/Penny Robins	1 month
During the inspection we were advised that call recordings were being retained by the practice indefinitely.	The practice must ensure that call recordings follow GDPR guidance and should be kept only for as long as needed.	(1) Telephone system provider has set up system for auto-deletion of recordings after set period (2) Documented period to be included in information governance /acceptable use policy	Andrew Langley Andrew Langley	Complete 1 month
The review of staff records highlighted gaps in mandatory training for both clinical and non-clinical staff, specifically Equality, Diversity, and Rights and Infection, Prevention and Control.	The practice must ensure staff are fully compliant with mandatory training.	(1) Equality diversity and rights part of induction training. To review content, and sign off. To review refresher training / e-learning training/ CPD discussion in team meetings. (2) IPC training. All relevant team members	Andrew Langley/Penny robins Jan Ryzy	3 months 3 months

		to complete elearning. New joiners to complete IPC training if necessary for role. Update training matrix with any outstanding training. (3) Review above training regularly – refreshers. Standing item as part of appraisal	Andrew Langley/Jan Ryzy	Ongoing

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): **Andrew Langley**

Job role: **Practice Manager**

Date: **25.9.23**