GPC Wales guide to HIW Inspections

Background

'Doing Well, Doing Better: Standards for Health Services in Wales', http://www.wales.nhs.uk/sitesplus/documents/1064/Doing%20Well%2C%20Doing%20Better.pdf was published in April 2010 as standards to inspect services including general Practice.

The inspections are themed and the theme for 2014/15 relates to the Welsh government response to the enquiry report into the death of Robbie Powell.

Four main themes were identified

- Better communication and involvement with patients and their families;
- Accessing and managing medical records;
- Improving communication to ensure continuity of care; and
- Dealing with concerns and complaints following the death of a patient.

Before Inspection

The practice should get at least 4 weeks' notice regarding the inspection to give it time to make sure relevant personnel are available while maintaining the running of the practice as normally as possible.

The practice should feel free to phone HIW and ask for names of the visiting team, while also asking for information on specific areas that are to be inspected and any areas they could be challenged on.

Practices should inform their staff that the inspection is happening, develop a timetable for the day, and discuss what protocols could be looked at for example CGSAT areas.
It is important to remember that this is not meant to be an intimidating process and that HIW are keen that the process is to be reasonable and proportionate. If this proves not to be the case practices should liaise with their LMC.

The Inspection team usually arrive around 10am and will stay the whole day. The Inspection team will normally want to meet all involved in the visit for a short period, but staff can then go back to normal duties.

The Inspection

The team will include:

1. HIW inspection Manager
2. External HIW trained GP reviewer
3. Members of the local Community Health Council, who may separately ask questions about surgery 'experience'.
4. Practice Manager if a large practice is visited (large practice defined as having a10, 000 patients or more, or those with a branch surgery).

The team will need to spend some time with the practice manager, at least one GP, at least one nurse, at least one member of the administrative staff

If the practice is a multi-site practice, the reviewer will be able to access the records on the system from the main site.

A suitable room will be needed to meet the HIW team.

The practice should run as normal so not all staff will be needed at the same time but arrangements should be made to enable the team to spend some time with all the above mentioned personnel.

In general the visit will initially involve the whole inspecting team speaking with the practice manager and/or GP to get a feel for the practice, how the practice is organised, and run to ensure it is fit for purpose.

Usually the team then splits with the GP reviewer spending time with a GP looking at patient records – after this, the GP can usually return to clinical duties.

If the practice is a large practice or multi-site practice, the reviewer will be able to access the records on the system from the main site.

The HIW inspection manager will speak to staff and the Community Health Council members will speak to patients in the waiting room.

What sorts of areas will the HIW team be interested in?

They will want to look at evidence in the 4 areas outlined above – this might include:

- how the practice deals with incoming correspondence'
  This maybe letter / fax / email / phone messages- and how this is recorded and then gets into patient records.
- 'What process does the practice have for informing patients of abnormal results?'

There might not be any right or wrong answers - but the practice should be able to demonstrate it has a 'process' and varying staff members are familiar with it. Other questions will be asked about death notifications and complaints procedures

Having completed the CGSAT will put practices in a good position to demonstrate the governance they have in place.

Review of records

- The GP reviewer will be a GP – no other member of the inspecting team should be allowed to view the notes.
- The GP inspector will ask a GP to go onto a practice's computer system and open up a booked appointment day at random – they are subject to the same confidentiality arrangements are in place when others inspect clinical records on behalf of Welsh Government.
- The GP will then be asked to choose patients booked for a specific GP and to open up relevant consultation details for that patient so that the reviewer can read the clinical entry. The reviewer will be looking to satisfy himself that should the patient consult again (for that particular problem) that it is possible to ascertain the presenting symptoms/history, whether an examination (if necessary) relevant findings, and then what the management/treatment plan was together with any indication of follow up.
- It is accepted that for simple consultations or repeat medication, such detail will not necessarily be recorded.
- The reviewer will then ask to see the another consultation for the next appointed patient for the same GP and will continue to review records until they are able to form an opinion about the clinical records for that specific GP (GPC Wales has raised issues relating to how robust this subjective judgement is, but this is simply describing the process as it currently stands).
- The Reviewer will then ask to repeat the process for every other GP in the practice, again by looking at consecutive patients on the same particular day
- The number of records viewed may vary but is an average of 5 per GP –

- The practice should advise the reviewer if that particular sample 'day' was 'abnormal' (e.g. due to say annual leave / staff sickness / locum cancelling - so that they are aware that those circumstance may have impacted on the performance / workload being reviewed)

End of visit

The team then meets up to discuss the evidence gathered and a verbal report of the day's findings will be presented to the practice - the practice manager together with GPs should attend.

Good points will be acknowledged and advice given where areas could be improved / altered / amended if there are negative points - these will be highlighted - with suggested opportunities to reflect and alter / change. This verbal report should be 'formative' and provide support to the practice and stimulate discussion and clarification

If poor areas are identified - suggested remedial action will be proposed and verbally agreed with the practice. This will be followed up by a written invitation to demonstrate an action plan has been put in place in an agreed time frame – rarely a follow up visit may be required.

After the Inspection

Within three weeks of the visit a draft report will be sent, to the practice for them to check for factual accuracy.

The community Health council will also get a copy of the report to check their comments are accurately reported.

This report will NOT identify or specifically reference any names of the staff or clinicians within the report. The report may however say that 'the inspectors found that evidence where the practice's record keeping fell below a particular standard and agreed actions have been put in place'.

The practice will be afforded the opportunity to correct any factual inaccuracies (not subjective opinions) prior to the final report being completed.

If recommendations are made in the report, the practice will be asked to provide an action plan to tell HIW how they will address the issues raised by the inspection. This will have already been highlighted to the practice in the verbal feedback. The LHB will be sent a copy of this.

Within three months a final copy of the report will be sent to the practice, The Health Board and the local CHC. It will also be published on the HIW website alongside any action plan provided by the practice.

The HIW reports are in the public domain – but individuals will NOT be identified.