General Practice Inspection (Announced)

Skewen Medical Centre,

Swansea Bay University Health Board

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

Our purpose

To check that people in Wales receive good quality healthcare

Our values

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

- Independent
- Objective
- Caring
- Collaborative
- Authoritative

Our priorities

Through our work we aim to:

Provide assurance:	Provide an independent view on the quality of care
Promote improvement:	Encourage improvement through reporting and sharing of good practice
Influence policy and standards:	Use what we find to influence policy, standards and practice

1. What we did

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Skewen Medical Centre at Queens Road, Neath, SA10 6UH, within Swansea Bay University Health Board on the 18 November 2019.

Our team, for the inspection comprised of a HIW inspection manager (inspection lead), GP and practice manager peer reviewers and a lay reviewer.

HIW explored how the service met the Health and Care Standards (2015).

Further details about how we conduct GP inspections can be found in Section 5 and on our website.

2. Summary of our inspection

Overall we found evidence that the service provided safe and effective care. However, we found some evidence that the practice was not fully compliant with the Health and Care Standards in all areas.

We observed positive and friendly interactions between staff and patients. The environment was welcoming to all, and patient's comments were generally positive about the practice.

Communication between staff within the practice was reported as good, and staff told us they felt supported by the management team.

We found areas of concern that could pose an immediate risk to the safety of patients, including processes in place for ensuring staff had appropriate Hepatitis B immunity and processes for the safe recruitment of staff.

This is what we found the service did well:

- Appropriate arrangements in place for medicines management
- A range of services available to patients including information on health promotion as well as regular clinics for ongoing conditions
- Comprehensive business continuity and emergency plans in place.

This is what we recommend the service could improve:

- A review of the policies and procedures to ensure they all are up to date
- The practice should complete an updated environmental risk assessment
- The practice should ensure that medication fridge temperatures are adequately recorded

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

3. What we found

Background of the service

Skewen Medical Centre currently provides services to approximately 9,000 patients in the Skewen area of Neath. The practice forms part of GP services provided within the area served by Swansea Bay University Health Board.

The practice employs a staff team which includes six GP partners, one salaried GP, one physician technician, two nurses, three healthcare assistants, seven administrative staff, nine receptionists and a practice manager.

The practice provides a range of services, including:

- Minor surgery
- Diabetes clinic
- Respiratory clinic
- Warfarin clinic
- Contraception fitting
- Vaccinations.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

Patients told us they were happy with their care and they were treated with dignity and respect.

The staff team were clearly focused on the need to create a calm and pleasant environment within the practice. We also saw a range of information on notice boards to give advice on good health and support groups such as carers support and mental health support.

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.

In total, we received 47 completed questionnaires. The majority of the patients who completed a questionnaire were long term patients at the practice (those that had been a patient for more than two years).

Patients were asked in the questionnaire to rate the service provided by this GP practice. Responses were positive; almost all of the patients rated the service as excellent or very good. Patient comments included:

> *"The doctor is extremely helpful and always has time to listen to my concerns and is willing to help with anything she can"*

> *"My husband and I have never been refused an appointment when needed or in an emergency"*

> *"The practice operates the 'telephone first' model which I much prefer to traditional appointment systems"*

Patients were asked in the questionnaires how the GP practice could improve the service it provides. Patient comments included:

> *"Make it easier to book appointments with the GP. Difficult having to phone and wait for a call back when working full time"*

“Have more appointments and not telephone triage and receptionist do not ask do you need to see doctor”

“Would be helpful to have Saturday morning clinic”

Staying healthy

We saw there was a variety of posters displayed in the practice waiting area, for patients to read whilst waiting for their appointment. We also saw that the practice had a notice board which showcased a wide range of information on good health and support for initiatives, such as healthy eating. We were told the theme of the information displayed changed monthly.

Dignified care

Every patient who completed a questionnaire felt that they had been treated with dignity and respect by staff at the practice.

We observed patients being greeted and welcomed by reception staff in a professional and friendly manner. Reception staff told us that a room could be used rather than reception if required, for patients to discuss any personal or sensitive information.

The majority of patients who completed a questionnaire told us that they could always get to see their preferred doctor, however, around a third of the patients told us they could only sometimes see their preferred doctor.

We were able to see that during appointments the doors to the consultation rooms were closed, to protect patient privacy. Some of the consultation rooms were divided into two areas, with the treatment couch being in a separate area. This meant that patients were able to undress in privacy when required, prior to any treatment or examination. We saw that the doors could be locked to ensure privacy was maintained.

There were a number of staff trained to appropriately provide a chaperone service for patients during intimate examinations, and this was clearly advertised to patients.

Patient information

The vast majority of the patients who completed a questionnaire told us that they would know how to access the out of hours GP service.

The practice had a practice leaflet which contained information for patients about the practice and the services it offered. The leaflet was available at the reception desk.

Communicating effectively

All but one of the patients who completed a questionnaire told us that they were always able to speak to staff in their preferred language.

We were told that there were Welsh speaking staff at the practice. In addition, people could receive a service in a language of their choice, and we saw evidence that the language line was offered if a patient's first language was not English or Welsh. Whilst written information was available, this was predominantly presented in English. Arrangements should be made to provide information in Welsh and to help staff make an 'Active Offer'[1].

The practice had a hearing loop to aid communication for patients with hearing difficulties, and we saw a poster advertising this in the waiting area.

Every patient who completed a questionnaire felt that things are always explained to them during their appointment in a way that they can understand, and all of the patients told us that they are involved as much as they wanted to be in decisions made about their care.

Timely care

All but one of patients who completed a questionnaire told us that they were very satisfied or fairly satisfied with the hours that the practice was open. The majority of patients who completed a questionnaire said that it was very easy or fairly easy to get an appointment when they needed one.

We found that the practice made efforts to ensure that patients were seen in a timely manner. Staff also described a process for keeping patients informed about any delays to their appointment times, telling us they would verbally update patients.

[1] An 'Active Offer' means providing a service in Welsh without someone having to ask for it. http://gov.wales/topics/health/publications/health/guidance/words/?lang=en

We were told that requests for same day appointments were triaged, and then patients would be either offered an appointment with a relevant healthcare professional, or signposted to another service. The practice also promoted Choose Pharmacy[2] for minor ailments.

When asked to describe their overall experience of making an appointment all but three of the patients who completed a questionnaire described their experience as very good or good.

Staff told us that there was an open door policy for staff, and that they would be happy and confident to speak with the GPs, should they need advice regarding those patients being triaged, including the timeliness and appropriateness of appointments.

Individual care

Planning care to promote independence

The practice was accessible to patients using wheelchairs, those with mobility difficulties, and for those with pushchairs, as the patient area was all on ground floor.

The practice held clinics for patients with specific ongoing healthcare needs, such as asthma and diabetes, to help support them in the management of their conditions.

People's rights

Our findings that are described throughout this section indicate that the practice was aware of its responsibilities around people's rights.

Listening and learning from feedback

The practice had a new process in place to obtain patient feedback. This included a comments form that patients could complete anonymously and place

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[2] http://www.choosewellwales.org.uk/sitesplus/documents/994/Minor%20Ailments%20Services_Leaflet_English.pdf

in the suggestion box. We discussed the arrangements for the completed feedback with the practice manager, who confirmed that the plan was to analyse and discuss feedback with staff in team meetings. From this, any changes to the practice as a result of this feedback should be communicated to patients.

We saw that the NHS Wales Putting Things Right[3] process was displayed in the reception area. The practice held a complaints policy and a folder for patient complaints, and kept a record that demonstrated the actions they had taken.

[3] http://www.wales.nhs.uk/ourservices/publicaccountability/puttingthingsright

Delivery of safe and effective care

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

The practice was kept to a good standard to minimise the risk to staff and patients.

Patient records were maintained to a good standard.

Clinical staff reported that there was a positive working relationship, which enabled regular peer review.

We saw that the most recent environmental risk assessment was out of date and the actions had not been fully completed.

More robust arrangements were required to ensure that records of staff hepatitis B immunisation status was documented.

Safe care

Managing risk and promoting health and safety

During a tour of the practice, we found that it was clean and uncluttered, which reduced the risk of trips and falls to patients and staff. However, we found during the inspection that an environmental risk assessment had not been completed in the past 12 months. This is important to ensure that the practice environment remains safe and fit for purpose. We also saw that not all of the actions from the previous risk assessment had been completed within the agreed timescales.

We found that checks of the fire safety equipment had been carried out. We also saw that staff had completed fire safety training.

Improvement needed

The practice must ensure that an environmental risk assessment is carried out on a regular basis, and the actions completed within the agreed timeframes.

Infection prevention and control

Staff told us that they had personal protective equipment, such as gloves and disposable plastic aprons, to reduce the risk of cross infection. The clinical treatment areas we saw were all clean and tidy.

We saw that hand washing and drying facilities were provided in clinical areas and toilet facilities. Hand sanitisers were available in the treatment rooms to GPs and nurses, and upon entrance to the practice there was a hand sanitiser available to all.

We were satisfied from a sample of staff records that all appropriate staff had completed infection control training.

There were no concerns given by patients over the cleanliness of the GP practice; all but one of the patients who completed a questionnaire felt that, in their opinion, the GP practice was very clean.

The practice did not maintain an overall register of the hepatitis B immunisation status for their clinical staff. This is required to protect staff and patients. Our concerns regarding the above issue were dealt with under our immediate assurance process. This meant that we wrote to the practice immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in Appendix B.

Medicines management

We reviewed the arrangements for the storage and handling of drugs and equipment to be used in a patient emergency (such as collapse). The Resuscitation Council UK Quality Standards for Resuscitation[4] stipulate, that healthcare organisations/ providers have an obligation to provide a high-quality resuscitation service. We saw that the emergency kit was of a high standard and included all of the equipment required by the Resuscitation Council UK.

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[4] Resuscitation Council UK Quality Standards for Resuscitation

We found that the practice had a process in place for checking and recording the emergency drugs and equipment on a regular basis, to ensure items remained safe and ready to use and within their expiry dates.

We saw that cardiopulmonary resuscitation (CPR) training was carried out on an annual basis for all staff.

Medication and vaccinations were stored in a locked medication fridge within the treatment room. Whilst we saw that checks had been carried out of the medication fridge temperature, the records showed that the checks had been missed on one occasion. It is important for medicines and vaccination to be stored at the correct temperature to ensure they remain viable and safe to use, and checked on a daily basis.

Improvement needed

The practice must ensure that daily checks are undertaken of the medication fridge temperatures.

Safeguarding children and adults at risk

We saw that the practice had safeguarding policies in place to protect children and vulnerable adults. The safeguarding lead for the practice was identified within the policy. We did not see a copy of the All Wales safeguarding guidance was available to staff within the office and recommended that this should be made available.

We reviewed a sample of staff records and found that they had received appropriate training in safeguarding of children and vulnerable adults.

Medical devices, equipment and diagnostic systems

We saw that the practice had a process in place to ensure that medical equipment was serviced and calibrated to help make sure they remained safe to use.

Effective care

Safe and clinically effective care

The practice had arrangements in place to report patient safety incidents and significant events. The sharing of safety alerts received into the practice was

appropriately managed by the practice manager and shared with relevant staff. We found that any significant incidents were discussed during team meetings.

We spoke with members of the practice team on the day of our inspection, and were able to confirm that staff were encouraged and empowered to raise any concerns they may have about patients' and/or their own safety.

Information governance and communications technology

We found that in each surgery, confidential waste was stored in open boxes which could be seen from patients' seats. This left potentially confidential information open to being accessed by members of the public.

Information systems were password protected, and patient records were held securely in offices which were not accessible by the public.

Improvement needed

The practice must ensure that confidential waste is stored appropriately.

Record keeping

We looked at a sample of patient records and overall, found they were of a good standard. We found that consent was not consistently recorded and recommended that the practice must ensure that this is rectified to ensure the records are maintained to a consistent standard across the practice.

Improvement needed

The practice must ensure that consent is recorded appropriately within patient records.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how services review and monitor their own performance against the Health and Care Standards.

We found that practice staff were well supported by the practice management team and were positive about opportunities for training and development.

Management and clinical team meetings were in place along with processes to share information, and staff told us they felt well informed.

We identified that improvement was needed to ensure the staff training information was up to date, staff have DBS checks and relevant recruitment checks are undertaken.

Governance, leadership and accountability

We found that there was a cohesive practice team, who worked well together and supported each other. There was evidence of good relationships between members of the management team and the practice staff, and we found that staff morale was high during the inspection. Staff told us that communication was good within the practice, and that they felt supported by the management team.

There were six GP partners within the practice, with the responsibility of the day to day running being managed by a practice manager.

Nursing staff we spoke with told us that they felt supported by the GPs. They told us they were able to raise any clinical concerns with them at any time during the course of the day.

There were a number of meetings held within the practice, to share information between staff. These included clinical and non-clinical staff meetings. We were told that they would invite other parties, such as district nurses, palliative care

teams into some clinical meetings when and where appropriate. Staff told us that communication was good within the practice, and felt like they were able to openly discuss any issues that were concerning them.

There were a number of policies and procedures in place, which were available online to staff. Some of these were in need of updating to ensure they were relevant to the practice, and contained the most up-to-date information. The practice was reminded to ensure that any changes made to policies or procedures are clearly communicated to all staff.

Improvement needed

The practice must ensure that policies and procedures are kept up to date and reviewed regularly.

Staff and resources

Workforce

There was a well-established staff team in place, with many staff members being employed for a number of years. A new practice manager had been appointed within the past six months, and as a result a number of procedures were currently under review.

Staff were able to describe their roles and responsibilities in detail, and demonstrated a good understanding of the practice procedures.

We looked at a number of staff training files, and were able to see that records of training undertaken had been kept. However, the practice training matrix, which records the training undertaken for all staff was out of date. It was therefore difficult to conclude quickly that all staff had received all the relevant training within appropriate timescales, and to ensure their skills and knowledge were kept up to date. Staff we spoke with told us they have access to in-house and online training, and felt supported by the practice to do this.

We were able to see that a process of staff appraisals had begun, and was scheduled to be concluded before December 2019.

We found that there were limited processes in place to support the safe recruitment of staff. It was unclear, through discussions with the practice manager and through reviewing a sample of staff records, whether newly

appointed and existing staff had received all the appropriate checks, to support safe recruitment and ongoing employment. There was no evidence that the relevant checks had been undertaken. This included a Disclosure and Barring Service (DBS) check, professional registration check, hepatitis B check, qualifications and training records.

A review of other staff files and discussion with the practice manager confirmed that staff who had been employed for long periods of time had not had a DBS check.

Our concerns regarding the above were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

In light of the above issues with regards to recruitment, the practice must ensure that they have a robust process in place for any recruitment and appointment of staff in the future. This must include carrying out the relevant pre and post appointment checks.

Clinical staff are required to register with their professional body, such as the General Medical Council (GMC)[5] or the Nursing and Midwifery Council (NMC)[6]. They must also revalidate their registration with evidence of practice and training at defined intervals. Whilst it is an individual's responsibility to ensure their registration is maintained, the practice did not have a clear process in place to monitor this, to ensure that staff remained registered with their professional body.

Improvement needed

The practice must:

- Maintain a clear record of staff training, and ensure that staff attend training within appropriate timescales
- Implement a clear and robust recruitment policy to ensure that all

[5] https://www.gmc-uk.org/

[6] https://www.nmc.org.uk/

pre and post appointment checks are completed, prior to a new member of staff commencing employment.

- Implement a clear and robust process to monitor and check that staff maintain their professional registration.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

5. How we inspect GP practices

GP inspections are usually announced. GP practices will receive up to 12 weeks' notice of an inspection. This is so that arrangements can be made to ensure that the practice is running as normal, and that the inspection causes as little disruption to patients as possible.

Feedback is made available to practice representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

We check how GP practices are meeting the Health and Care Standards 2015. We consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within GP practices.

Further detail about how HIW inspects the GP practices and the NHS can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
There were no immediate concerns identified on this inspection			

Appendix B – Immediate improvement plan

Service: Skewen Medical Centre

Date of inspection: 18 November 2019

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
Finding The practice was not able to provide evidence of Hepatitis B immunity for all clinical staff. **Improvement needed** The practice must provide HIW with evidence of the Hepatitis B immunity status for all clinical staff. Where evidence is not available to demonstrate immunity, appropriate action must be taken by the practice to protect staff and patients.	2.4 Infection Prevention and Control	Undertook an audit of the existing Hep B register and staff personnel files within the Practice. Register updated to reflect current staff Hep B status and requested results for those staff who did not currently have their immunity status on file. All staff will be risk assessed on a annual basis.	Practice Nurse	Complete
Finding	7.1			

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
The practice did not have Disclosure and Barring Service (DBS) checks completed for all relevant staff. **Improvement needed** The practice must ensure all staff (where applicable to their roles), have DBS checks completed, with a record kept on file, to a level appropriate to their roles.	Workforce	In the process of DBS checks for all staff both standard and enhanced where relevant. A number of forms have already been sent off and awaiting the DBS certificates. Working closely with Shared Services to sign off relevant documents needed. All certificates should be complete and received for staff files by end of December. A process is in place for all new staff to have a DBS check. Annual audit will take place to review.	Faye Killick	Three months

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: Skewen Medical Centre

Date of inspection: 18 November 2019

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Delivery of safe and effective care				
The practice must ensure that an environmental risk assessment is carried out on a regular basis, and the actions completed within the agreed timeframes.	2.1 Managing risk and promoting health and safety	A risk assessment review was undertaken on 16th January with MDU, this will be reviewed regularly	Faye Killick Practice Manager	Complete and will be reviewed regularly
The practice must ensure that daily checks are undertaken of the medication fridge temperatures.	2.6 Medicines Management	This has been addressed and a system in place for when the Practice Nurses are both on leave this will be recorded by the HCSW	Rebecca Evans Practice Nurse	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
The practice must ensure that confidential waste is stored appropriately	3.4 Information Governance and Communications Technology	New confidential waste bins have been purchased	Faye Killick Practice Manager	Complete
The practice must ensure that consent is recorded appropriately within patient records.	3.5 Record keeping	All consent is documented – scanning team been advised not to delay scanning of documents	Faye Killick Practice Manager	Complete
Quality of management and leadership				
The practice must ensure that policies and procedures are kept up to date and reviewed regularly.	Governance, Leadership and Accountability	New Practice Manager in post and all policies and procedures have been updated with a spreadsheet to document review date	Faye Killick Practice Manager	Complete
The practice must: • Maintain a clear record of staff training, and ensure that staff attend training within appropriate timescales • Implement a clear and robust recruitment policy to ensure that	7.1 Workforce	Staff mandatory training is now complete and training matrix updated to enable regular reviews All staff have had recent DBS checks standard/enhanced. New recruits will	Faye Killick Practice Manager	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
all pre and post appointment checks are completed, prior to a new member of staff commencing employment. • Implement a clear and robust process to monitor and check that staff maintain their professional registration.		have relevant checks A system will be implemented to monitor staff professional registration	Faye Killick Practice Manager Faye Killick Practice Manager	January 2020

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): FAYE KILLICK

Job role: PRACTICE MANAGER

Date: 16.01.2020